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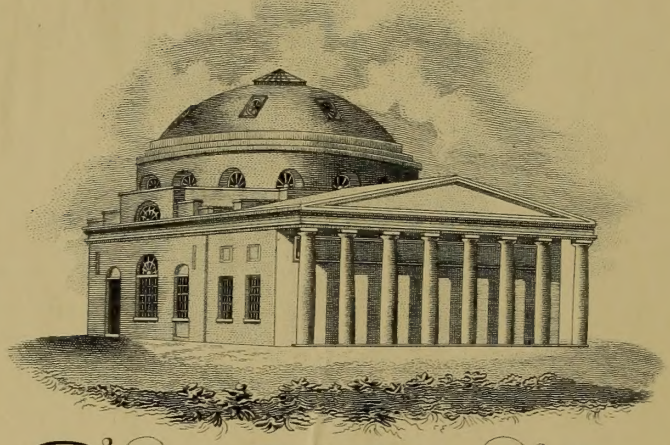

University of Maryland

University of Maryland Theses

Early Doctor of Medicine and Doctor of Physic Dissertations with Corrected Tables of Contents

These manuscripts described as either an Inaugural Dissertation or an Inaugural Essay were presented to the University of Maryland for the Degree of Doctor of Medicine and/or Doctor of Physic during the years 1813-1887. The individual dissertations were bound together during the 1940's. The original tables of contents for the bound volumes contained multiple errors in authors' names, titles, and/or years. To address these errors, an additional "Corrected Table of Contents" has been inserted at the beginning of each volume.

The project team who investigated and corrected the tables of contents were Richard J. Behles, Historical Librarian/Preservation Officer; María Milagros Pinkas, Metadata Management Librarian; Angela Cochrane and Carol Harling-Henry, Resources Division; Sarah Hovde, Abra Schnur and Megan Wolff, Services Division.

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UNIVERSITY OF MARYLAND

THESES

1883 (b)

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Shirley, J. Fletcher	Cholera Infantum	
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[1] Pages 12-23 of "Dislocation Thesis" from 1883, 1889 volume, are inserted after page 19 of "Diphtheria"
[2] Noteworthy color calligraphy on name page and title page. Contains footnotes.
[3] Author, title information on last page.

HSHSL 2012 for the UM Digital Archive. Sources consulted for corrections: Original Dissertation; University of Maryland Medical Faculty, Matriculation List, 1851-1892; Cordell, Eugene F. "University of Maryland, 1807-1907" (New York : The Lewis Publishing Company, 1907), Volume 2.

Author	Title	Notes
Watkins, William W.	Diphtheria	
Day, Baldwin	Respiration	
Talbot, Lewis Wilson	Syphilis	

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UNIVERSITY OF MARYLAND

THESES

1883 (b)

Frum, L. D.	Pneumonia	24p.
Benton, ~~J.~~ John R.	Diphtheria[1]	31p.
Shirley, J. ~~F.~~ Fletcher	Cholera Infantum	22p.
Shipley, ~~B.~~ Benjamin F.	Some Remarks on Syphilis	42p.
Gillilaud, ~~R.~~ Robert J. Jr.	Diphtheria	30p.
Dillard, B. L.	Rubeola	17p.
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Wareham, E. A.	Diphtheria[2]	33p.
Robinson, ~~J.~~ John H.	Lobar Pneumonia	20p.
Williams, ~~B.~~ Bayton B.	Whooping Cough	19p.
Nixon, ~~J.~~ James W.	Intermittent Fever	19p.
Robinson, ~~J. A.~~ John Albert	Syphilis	19p.
Hart, ~~J. B.~~ John Beauregard	Typhoid Fever	23p.
Watkins, ~~Wm.~~ William W.	Diphtheria	18p.
Day, Baldwin.	Respiration[3]	29p.
Talbot, ~~L. W.~~ Lewis Wilson	Syphilis	29p.

1 - Pages 12-23 of "Dislocation" thesis from '1883, 1884' volume appear after page 19 of "Diphtheria"

2 Noteworthy color calligraphy on name and title page. Contains footnotes.

3 Very small pages

57

[illegible]

[illegible]

[illegible]

on the abnormal quantity of blood in the lung. If the progress of the disease is favorable, the exudation is removed mainly by absorption; but should it be unfavorable absorption of the morbid products within the aircells does not take place and the affected [illegible] are infiltrated with fibrin and puss. When the lung is in this condition it is called the stage of purulent infiltration. Pneumonia is divided into three stages viz engorgement, red hepatization, and gray hepatization. The first stage or stage

of engorgement the lung is
vascular. The changes in the
blood vessels and circulation
take on all the characteristics
of inflammation. The lung is
solidified and its weight
is increased and its elasticity
is diminished, and it sinks in
water. The second stage
or stage of red hepatization
is this stage there is exudation
and migration of blood
corpuscles into the pulmonary
tissue. In this stage some of
the vessels may rupture. The lung
in this stage is heavier than
in the preceding stage, and

is increased in size so as is
said to be often marked by
the ribs. In this stage we do not
have it capitate [illegible] the finger
as in a normal lung. The
pleura in pneumonia of this
stage covering the lung is more
or less involved in inflamation.
It is of an opaque color and is
generaly covered with lymph.
The third stage or stage of
gray hepatization. In this
stage the white blood-corpus-
cles continue to escape from the
vessels, and their number
in the alveoli gradually incre-
ases. The tissue becomes

completely [illegible] with the [illegible] and fibrinous exudation is abandoned [illegible] it is in this stage that we have red hepatization. Pneumonia is said to terminate in the four following ways. First in Resolution in which the lung gradually return to its normal condition; this termination is most frequent in croupous pneumonia. In this process the matter becomes softened and absorbed; and circulation become reastablished. In the second process that of [illegible] this process is not often seen

and is favored by a bad constitution or circumstances which tend to impair the general health and the abuse of alcohol have a tendency to aid in the formation of abcesses. Gangrene may terminate this process. The upper lobe have the greatest tendency to take on this process. Third stage that of gangrene. This process is rarely seen and is mostly seen in old drunken cases. When gangrene does occur it is generaly limated to a small space in the effected lobe. Fourth process that of Chronic pneu-

-monia the alveolar walls
gradual become thickened of
a new growth of tissue. Accord
ing to test looks to clinical
history shows the chlorides are
frequently diminished or entirely
disappear while the process of
exudation is going on, and
after solidification has taken
place, until resolution begins.
This can be ascertained by
adding nitrate of silver and
nitric acid to the urine.
This test if the chlorides be
present it will give off a
cloudy precipitate [illegible]
[illegible] the disappearance of the

chlorides is not pathognomonic for this is observed in other diseases. In pneumonia the urine is diminished in quantity. The urae generally exceeds the amount in health. Symptoms and Signs There is a feeling of general malaise with chilly sensation, pain is felt in side. In the majority of cases there is a decided rior felt in the begining. The chilly sensation is soon followed by fever. The pain in the side is generally refered to a circumscribed space near the nipple. There is in a majority of cases a cough but

some exception. The face is flushed and generaly there is headache, [illegible] pain the back is felt. The pulse is full and strong. The temperature is increased. The tongue is usualy coated and is of a whitish furred. The appetite is generaly lost. The stomached usualy nauseated and vomiting may occur. There is difficult of breathing. The pain in the side varies in severity, as to the amount the pleura is involved. If the pleura is much involved the pain will be more prompt and more severe. In the beginning of pneumonia the pain is usualy more severe, and

gradually decline as the disease advances. Coughing, breathing especially deep inspiration will increase the pain. Respiration are generally more frequent and more shallow. A dusky [illegible] [illegible] [illegible]

called the crust of the spleen. The rust of the spleen, is said to be due to the matter mixed with the blood as it passes from the lungs. The pulse during the hyperæmic stage is full & strong; but as the disease goes on the pulse gradually [illegible] & [illegible] & [illegible] &

is well marked it is almost
patognomonic. Care should be
exercised as to the rales for
the subcrepitant rale is closely
allied to the crepitant rale; but
the distinction can be made
as follows: in the subcrepitant
by its fineness, dryness, and
limited to inspiration. There
is cases on record in which
both rales existed in combina-
tion. When solidification has
taken place, we have dull
[illegible] on percussion or a flat
like sound. When the [illegible]
is entirely solidified then
we have bronchial respiration

Pneumonia is a self-limited disease, and terminates by crisis or lysis. Delirium is [illegible] time present, but most [illegible] in patients that alcohol i[illegible] excess. Among the most rational [illegible] in [illegible] is the beginning with a chill or rigor followed by the increase in temperature, and the pain near the nipple. Also iron rust sputa and great pain in taking a deep inspiration. The [illegible] cases will rang from 102° 103° [illegible] light fall of the temperature

in the morning of each day, usu-
ally the temperature is about 1°
lower in the morning than at
[illegible] of the Progress of the
disease be favorable termination
the alveolia will gradual open
up for the air to enter, and
under favorable circumstance
the restoration of the lung is
completed in a few days. The
unfavorable termination
may be preceded by an abrupt
fall of temperature. The pulse
become weak and frequent
and dysphora increases. The
tongue become very dry, and
the face become cynosed

The breathing become quick and shallow. There is apt to be delirium of a low muttering character and finally just before death in the majority of cases there is profound coma. The principle complication of pneumonia are pleurisy bronchitis and phthisis. There is other diseases sometimes accompany pneumonia viz rheumatism joint, jaundice and pericarditis. The most frequent of all the complication are pleurisy (diagnosis)

Pneumonia is one of the easiest desease we have to diagnose if well developed. Dermisy and

[illegible]
the gravity and danger
depend on the age, compli-
cation, amount of [illegible]
involved and [illegible] the hy-
gienic situation of the
patient. Treatment Pneumo-
nia is classed as a self-
limited disease and there
being no specific in the
treatment our object is to
aid nature. Blood letting
may prove [illegible] but
is restricted to the first
stage. [illegible] condition which
favorit is [illegible] and
high febrile action resistant.

pulse, the condition of [illegible]
ora or at least of a robust
condition. Bloodletting is
always contra-indicated when
the pulse is weak or in case
the patient be [illegible]
or of a feeble constitution.
[illegible] most important is
good [illegible] and without
this rule is observed we will
not be able to get satisfac-
tory results from the med-
icinal treatment. The expec-
trant treatment is of great
advantage and should be
[illegible] in all stages.
[illegible] condition the use

[illegible] is [illegible]
ficial [illegible] [illegible]
[illegible] be given at bed time
Effervescent powder, Counter
irritation. Dry or acts c[illegible]
over the seat of pain. In
the first stage [illegible]
stops diaphoretics and subst-
[illegible] [illegible] may be
given in the first stage
Covers powder may be give
for its diaphoretic effect and
to alay pain Amonia Carb
should be given in this
stage. Spts [illegible] &c. In
the second stage [illegible]
In Catarrhal Pneumonia

generaly in children in
this never let a child lie
flat on back in bed
In the treatment of pneu-
monia much depends on the
expectorant treat — viz Syrp
Ipecac. Syrp Squill. Senegaric
In Typhoid Pneumonia this
requires stimulants from
the begining. The sick room
of a pneumonia patient
should be well ventilated
and plenty fresh air but
the patient should be
protected from [illegible] d [illegible]
of air [illegible] Pneumonia
Cod liver oil is indicated

Thesis

on

Xphthera

by

Jno. R. Reeton

1883.

Diphtheria

This is a contagious, infectious and sometimes epidemic disease, doubtless originating from a specific morbid material entering into the blood, giving rise to the characteristic exudation upon the fauces and mucous membrane of the mouth and sometimes extending to the air passages.

Anatomical Characters

The exudation is fibrinous and infiltrates the mucous membrane. Croupous exudation may closely simulate it. The tonsils, uvula, pillars of the fauces and the pharynx are the parts primarily affected in the vast majority of cases, larynx often

involved, and may extend to the trachea and to the large and medium sized bronchi. The eustachian tube and cavity of the middle ear may be involved.

Diphtheritic Conjunctivitis occurs in some cases, and involves considerable danger of loss or impairment of vision.

The lips' the anus the prepuce, vulva and vagina may be involved and it may also occur upon any part of the skin deprived of the epidermis.

Other parts may be involved at any stage of the disease. The false membrane is observed at first as a grayish-white, slightly elevated patch, which cannot be detatched whithout leaving a bleeding surface. As the membrane

increases in thickness it acquires a yellowish or dirty gray color, and may have a reddish or brown hue from admixture with blood. The exudation may be pulpy or firm. If firm it may be detached in a single layer. In the course of 3 5 days generally, the membrane becomes detached; or loosened so that it can readily be detached without injury to the soft parts; the mucous membrane may be left in tact or ulcerated. The disease may be attended by grave constitutional symptoms even when the false membrane is seated superficially. Outside of the pseudo-membranous exudations the mucous membrane is reddened.

It presents, usually, exchymoses in greater or less number. If the disease extends into the larynx it makes the prognosis bad. In the trachea & bronchi the membrane is loosely attached, and also in most parts of the larynx but on the epiglottis and vocal cords it is usually more firmly adherent. Pathologists are not agreed as to the exact structure of the diphtheritic membrane, but most of them regard it as composed of a net-work of fibrin enclosing epithelial and pus cells, and often granular matter and red blood cells. The exudation contains rod shaped bacteria.

It has not been proven that these

micrococci, have any special influence in causing the disease. The parts in severe cases may become necrosed.

Lymphatics in the neck are more or less enlarged especially those near the angle of the lower jaw. They seldom suppurate. Bronchitis & broncho pneumonia often complicate the disease. Where there was severe blood poisoning, there may be found after death, ecchymoses in the serous membranes, and parenchymatous degeneration of the heart, kidneys and liver and muscle.

The kidneys may be the seat of acute nephritis, as well as parenchymatous degeneration. Spleen is enlarged and softened.

Clinical History. — There are general and local differences in different cases. One marked point of difference is the development of the disease.

The attack is sometimes abrupt, commencing with a chill more or less ~~permanent~~ pronounced, followed by considerable or marked pyrexia; or the disease may begin with symptoms denoting great prostration.

Not infrequently the development is gradual and insidious, the patient complaining of indefinite ailments, and the throat affection may be discovered on inspection when there were few or no local symptoms pointing to the existence of the disease.

Symptoms are general and local after the development of the disease. The soreness of the throat is slight and in some cases the sensibility is diminished apparently. Incomplete paralysis of the muscles of deglutition is sometimes a concomitant of the disease, giving rise to difficulty in swallowing especially liquids, which may regurgitate through the nose. Breath is usually fetid. As a rule the gravity of the disease is commensurate with the extent of the local effection. Cough is more or less croupous, feebleness of the voice, and labored stridulous respiration, point to in-

involvement of the larynx. Laryngitis is excluded so long as the voice remains unaffected. Diminished respiratory action with moist bronchial rales, denotes an extension of the affection to the bronchial tubes. A mild case at the onset may develope into a serious case. An irregular pulse is unfavorable. Epistaxis is not infrequent. Hemorrhage occurs occasionally from the throat and mouth. The skin rarely presents much increase of heat, and it may be colder than in health. Temperature is usually lower than in most acute cases of disease. In grave cases the patient presents an anemic aspect, even

when hemorrhage has not occurred.
The disease has no characteristic eruption, if any occurs it is accidental.
Usually marked anorexia. Vomiting is frequent. Diarrhoea is not infrequent and is a symptom of bad omen. Mind is unaffected in a majority of cases. May have convulsions and coma, and the latter is the forerunner of a fatal termination; and is supposed to be due to uremia. Albuminuria is a frequent symptom, but the amount of albumen is usually small. Urine contains more than the normal amount of urea.
Acute Bright's disease may develope.

Duration;- from one to twelve. Death occurs in some cases within forty eight hours. It may continue for a long time owing to consecutive affections or sequels. It is diagnosed from scarlet fever by the absence of the eruption, strawberry-tongue and desquamation. It is diagnosed from croup by the false membrane being more superficial in croup and absence of swollen glands also by the disease beginning in the fauces and gradually working downwards and vice versa in croup. Diphtheria usually occurs as an epidemic.

Sequelae.

Anemia and general debility. neu-

ally exist for a time and sometimes feebleness of the hearts action. Paralysis effecting more or less of the voluntary and sometimes the involuntary muscles is a characteristic sequel. The muscles of the soft palate and pharynx are oftenest affected and usually precedes paralysis elsewhere. The palatine muscles are not usually affected for from 3-4 weeks after the date of convalescence; and it gives rise to regurgition of liquids through the nostrils and difficulty in swallowing. The soft palate is relaxed & immovable, and remains motionless if irritated with a sharp instrument as its reflex action is impaired.

The existence of paralysis in this situation is indicated by a nasal intonation of the voice, and sometimes by a snoring sound in respiration. Paralysis may effect the muscles of the tongue or face. Paralysis of the lower limbs is next in frequency, it is developed gradually, and is preceded by tingling, numbness and a sensation of coldness in the part. The paresis is of different degrees and may assume the form of hemiplegia. One of the upper extremities may be paralized in connection with paraplegia. The upper limb on one side and the lower limb on the opposite side may be

alone affected. In very rare cases there may be general paralysis. The sensibility of parts may be impaired as well as motion. The sensibility of the integument may be morbidly increased. The special senses are liable to be affected, especially the sense of sight. The external rectus is sometimes paralyzed causing converging strabismus. Presbyopia sometimes occurs and occasionally myopia. Partial or complete amaurosis sometimes occurs. Diaphragm and intercostal muscles are occasionly paralyzed, giving rise to dyspnoea. May affect the bladder giving rise to incontinence or retention of urine. Paralysis from diphtheria is functional,

and if it does not cause death, recovery may be expected after the lapse of a few weeks or months.

Pathological characters;

Diphtheria is a general disease. It is held by many physicians that the pyrexia and constitutional symptoms are the manifestations of a special morbid condition of the system, that is, they are secondary to the general disease, having a relation to diphtheria like that of the intestinal lesions of in typhoid fever. Some hold that the affection of the throat is primary as regards the general disease. It has not yet been proven that the existence of

the disease is due to micrococci.
In some cases septicemia is supposed be an important secondary element.
Diphtheria may end fatally without any affection of the larynx.
Diphtheria is a general disease or essential fever.

Causes: diphtheria is rarely sporadic is usually an epidemic disease. It is thought by some to be contagious. It is portable. Bad hygiene favors both the epidemic & sporadic forms. Often the special causes seem to be peculiar to certain localities. It may occur at any age but in the majority of cases it occurs in children

between three and twelve years of age.
Incubation period varies between two and eight days. The disease is more fatal in some diseases than in others.

Diagnosis:- it is recognized by its local diphtheritic characteristics. The exudation is usually preceded by pyrexia. The diphtheritic exudation has the characteristics of a false membrane is more extensive than in croup and is usually exfoliated in from thirty six to forty eight hours.

Prognosis:- is unfavorable. Death rate varies. Danger of diphtheritic laryngitis diminishes after the first

the week. Diphtheria may cause death from exhaustion. The violence of the attack may cause death in forty eight hours. If the larynx is effected or the mucous membrane of the mouth or posterior nares is extensively involved the prognosis is unfavorable. Frequent vomiting, diarrhoea, copious epistaxis or hemorrhages in other situations, frequent and feeble pulse, coldness of the surface, albuminuria, convulsions and coma are all unfavorable symptoms. Thrombus in the right cavities of the heart may cause sudden death as may also parenchymatous degeneration of the heart.

The treatment :- Is local and general. Gargles of Chlorate Potae, or Sodae, are good also alum. Quinia & Fe, chloride iron are good. Corrosive sublimate in 1/32 gr. doses is good. Chloroform and ether are both recommended. Lactic Acid used in spray has done good. Turpentine and small doses of cod liver oil are good. Caustic applications have given place to antiseptics as carbol. or salicylic acid. Permanganate of potassa, chloral hydrate, sulphite sodium etc. are all recommended and may be used with good effect in many cases. The principle danger of the disease if it does not involve the larynx

is from asthenia and therefore such a case calls for supporting treatment and the use of alcohol in these cases is the best treatment. Quinnen tation is an essential part of the treatment. Inhalations of warm vapor aid expeling the membrane. The patient should be isolated and disinfectants freely used. Spray the throat frequently with aqua calcis and acid corbol. If the local effection is very severe may pencil the part with silver nitrax. If necessary food may injected into the stomach or given by enema. Bichride mercury with bismuth and calomel is good. Tracheotomy in some cases.

only so long as this extension is continued. In dislocation on the contrary the natural movements of the joint are impeded, and the bones more or less fixed in their new position; they offer considerable resistance to reduction, but when reduced remain so.
Separations of epiphyses are to be distinguished from dislocations by several characters: First, Separation of an epiphysis can only occur at such ages at which it is normally separate from the shaft; whereas a dislocation may

take place at any age.

Second: A separated epiphysis is, as a rule, easy to reduce and difficult to retain; a dislocation presents the opposite conditions.

Third: Separation of an epiphysis is usually complicated with fracture, and thus crepitus may be elicited, which is not the case in a dislocation. As the general indications for treatment are the same, an error in diagnosis would be more mortifying to the surgeon than prejudicial to the patient.

[illegible] injury, especially if the injury is recent and the patient is suffering much pain, reduction should be at once attempted; at least this should be the rule in all joints save that of the hip where it may be advisable to wait until an anesthetic can be procured. There is always a fair chance of reducing a recent dislocation without any appliances or assistance; although from peculiar complications, or from great muscularity of the patient

pail or may occur in many.
In order to reduce a dislocation
the body must first be fixed,
and next the limb must be
either pulled or manipulated
in the most advantageous direc-
tion until the limb has been
restored to its proper length
and the head of the bone is in
its natural position. In the
majority of recent and simple
dislocations all that is neces-
sary is to know the anatomy
of the part, with the rules
applicable to the species in
every under treatment and
then to make manipulation

in the manner indicated by those rules. But in more complicated and less recent cases something must be done to relax or subdue the muscles. It was formerly considered necessary for this purpose to reduce the powers of the patient by venesection and tartar emetic, but this method has now been entirely superseded by the use of chloroform and other anaesthetics. In no other part of operative surgery has the discovery of anaesthesia made a more complete revolution than in the treatment of dislo-

cation, so that what was frequently a most difficult and always a painful operation, has now become comparatively painless and usually quite easy. The rule, therefore, in all dislocations which cannot be reduced by the first attempts which the surgeon makes with his own unaided force, is to administer an anaesthetic having the necessary apparatus for making forcible extension at hand, in case it should be required. The only exception to this rule is when, from concomitant disease or injury,

chloroform or ether is, in the
judgment of the surgeon, contra-
indicated. But this reason acts
also to contraindicate the forcible
attempts at reduction, or even with
the contra-indication be a disease
of the heart, this condition would
also forbid a forcible, prolonged,
and painful operation; and if
the complication of other injuries
renders it unadvisable to anaes-
thetize the patient no objection
exists to waiting until the
effects of such injuries subside
before attempting reduction.
In former days the contraction
of the muscles used to be over-

course by the introduction
of a narcotic [illegible]
in the [illegible]
[illegible]
[illegible]
[

cated instead of the one below,
as, for instance, above the elbow
in dislocations at the shoulder
rather than below. The limb
or part above the dislocation
is fixed by means of another

Should this attempt fail it may be renewed or the limb may be bandaged in the position which it has now assumed and a fresh trial made on the next or some day. It is frequently advisable in old dislocations where the displaced bone has contracted adhesions to limit the first extension to breaking down these bands, postponing all efforts at complete reduction until another time. Reduction having been accomplished the position of the joint must be main-

tained by bandages and splints, for a certain time, which varies somewhat in the different joints. If this precaution is omitted the head of the bone will almost certainly slip out of its articular cavity and the dislocation be reproduced, or even where this does not occur the motion of the joint will cause some amount of effusion which will interfere with the proper union of its ligaments and leave the joint permanently weak.

Hence it is important to keep the parts at rest during a sufficient time, although the opposite extreme must also be avoided, as too protracted inaction may cause troublesome or even permanent ankylosis. When from any cause reduction fails, much judgment and care are required to determine whether the attempt should be renewed or abandoned. The discredit of leaving the patient to his fate will weigh, powerfully in favor of perseverance, but serious mischief

to be attributed to this cause
at the same time to distribution
[illegible]
semble sometimes so closely those
of Asiatic cholera that the dis-
[illegible]
[illegible]
[illegible]

[illegible]

of Asiatic cholera. At the [illegible]
time uncontrollable vomiting sets
in every thing swallowed being
[illegible]
[illegible]
[illegible]
[illegible]
[illegible]
accompanied by the most intense
thirst: the infant eagerly takes
any fluid [illegible] in order to
relieve the tormenting demand
The tong is moist at first
[illegible]
fur Fever exists in a high
degree, in most cases, in fact
in no infantile malady is the

[illegible]
has set in — the thermometer
frequently making as high as
105° or even 108° degrees Fahren-
heit temperature In some very
rapidly fatal cases, however the
fever is entirely wanting — the
patient dying before the
[illegible] reaction takes place
The [illegible] is accelerated, small,
[illegible]
the [illegible], [illegible], [illegible]
sunken, [illegible] livid, [illegible] countenance
[illegible], [illegible] contained
drawn angles of the mouth, great
restlessness, rolling of the head
and tossing from side to side
to be followed by [illegible]

[illegible]

changes grade from the simple
hyperaemia of the mucous membrane
[illegible]
[illegible]
[illegible]
[illegible]
[illegible]
common that are met with. They
first enlarge and become white,
then of a [illegible],
then soften and ulcerations follow.
Sometimes [illegible]
deposits are met with upon the
follicles and ulcerated spots.
The lungs, liver, Kidneys and
all the other [illegible]

[illegible] The [illegible] action
of the mucous membrane being
reversed, instead of taking up
the fluid contents of the intestines
by absorption and carried
[illegible]
tissues waist may be [illegible]
that action [illegible]
[illegible]
[illegible]
[illegible]
[illegible]
rice water stools. We must come
to the [illegible]
is primarily a nervous one, and
that the [illegible]
[illegible]
the disturbed action of the

[illegible]

Diagnosis — The disease [illegible] which cholera infantum [illegible] to be confounded are [illegible] cholera and tubercular or simple meningitis, sun stroke, and cholera morbus; but with the exception [illegible] [illegible] [illegible] [illegible] meningitis constipation is the rule and when diarrhoea and vomiting [illegible] occur, they are slight compared with cholera infantum. [illegible] greater in meningitis, and no lesions being found in the bowel on the post mortem table. But [illegible]

due to the [illegible] of the [illegible]
constituents of the blood through
a lesion of the nerves that
supply the stomachs and intestines
; and secondarily with an intense
inflammatory action of the gastro-
intestinal canal

[illegible] the [illegible] indications
to be observed; first to remove
the cause of the irritation; second
to change the disturbed condition
[illegible]
[illegible] the blood gaits through
[illegible] away; and
[illegible] the injured or
[illegible] a state of
[illegible] possible
[illegible]

[illegible] [illegible] [illegible]
[illegible] [illegible] [illegible]
[illegible] [illegible] [illegible]

[illegible]

[illegible]

Clothes wrung out of hot water [illegible] spices or mustard cataplasms applied to to the stomachs and bowels wit[illegible]

[illegible]

The medicine given by the mouth sub-nitrate of bismuth with crosotes and tinctures of opium deodorized [illegible] great use in allaying the [illegible]

[illegible]

action of the intestines. Lime water and carbolic acid are [illegible]

[illegible]

[illegible]

Quinine if there is reason to suppose a malarial origin given hypo-[illegible]

[illegible]

well established, and if the fever be of a very high grade, the thermometer reaching from 105° [illegible] always be taken in the rectum) the [illegible] be put in a vat of from 90° to 95° and allowed to remain in until the temperature is reduced [illegible]

[illegible] returned [illegible]
[illegible] The bath is to be repeated
[illegible] [illegible] [illegible]
[illegible] Small pieces of ice
[illegible] may be allowed in
reasonable quantities. The food
should restricted or if allowed
milk and lime water or oatmeal
[illegible]
and strained. If the strength
[illegible]
[illegible] leebled action of the heart
[illegible]
Good brandy is to be preferred
in small doses. After the acute
stage has passed, and the sim-
toms continue in a chronic form,
[illegible] must restore to the

[illegible]

[illegible]

[illegible]

the narrow contracted view of the sky and sun which alone are to be had in the midst of a great city. to the [illegible] pure mountain air soft sea breeze. [illegible] view of the sky and sun and wholesome and appropriate food It is wanderful how these puny thin shrunken little sufferers will fill out

Some Remarks
On Syphilis
By Benj. F. Sykes

University of Maryland
School of Medicine
Feb 10th 1883

Syphilis

The literary [illegible] of Syphilis has been extensively & richly cultivated. In deed the origin of the [illegible] the source of the disease, the time of its appearance, its subsequent course & more especially its treatment has led to many keen controversies. To the reader of its history & modes of treatment, from its early period down to the present time, by different authors would only astound & puzzle the tyro, but the only true pathway by which we beginners should persue, is to take up those facts which we are taught & laid down, & to accept those new ideas & [illegible] & carefully weigh them in the balance of rigid

[illegible] ation, [illegible] dint of hard
study & careful experience, to persue
that course, which proves to our best
advantage in alleviating the afflic-
-ted, Above all, our knowledge
of the cause & presence of the undivided
poison of Syphilis is involved in
ignorance, as deep & dark as can be
woven of warp & woof of mystery.
All we know of it, is the manifes-
-tation of its presence when existing
in the bearer, & its infectious & conta-
-gious property, when the virus is
brought in contact with a mucous
membrane or an abraded surface,
And that it commences with an
indurated ulcer, (with a few exceptions)
at the point where the virus enters
the economy, Except when obtained

[illegible] primary or initial lesion of syphilis (chancre) always has a period of incubation from the fact giving us a clear idea that it is constitutional from the very first appearance of the chancre & which is further proven by its autoinoculability being always negative, although this point has been really discussed as a doubt & even by some writers declaring it to be a local disease at first, & that abortive treatment, would save the patient with immunity for the future, & again there are a class of physicians (even at this enlightened age) who seem to make no distinction between the chancre & the chancroid (or the soft non infecting

ulcer) & subject both the disorders to their so called alterative treatment by vegetable compounds, which are entirely useless as an antidote against the specific virus & only benefit if at all, by acting on the secretions of the system & thereby enable the patient to stand under his loathesome burden. In comparing the venign effects of syphilis at the present day, with the account given by the different authors of its fearful ravages when it first made its appearance in Europe nearly 400 years ago & spread almost like an epidemic, seems to show that its morbid influence is getting weaker & weaker & may possibly in the long comming future be eradicated from the human

[illegible] if it should [illegible] a great curse would be removed from the earth, & healthy people once more established, for I am under the opinion that Syphilis is & has been the source of some of the many ills that exist at the present time, & the offspring of many mysterious symptoms of diseases that the physician has to encounter,

Some of the principle characteristics of Syphilis are (viz) — the following pts. that it commonly occurs but once in the same person. This axiom holds true in this as in other diseases which are both contagious & constitutional; That when a person has had them is indisposed to contract them again. Variola, Scarlatina, Rubeola, Pertussis & Vaccinia all follow this "law," & in

[illegible] [illegible] [illegible] [

~~period of the initial lesion~~

have decided proof of a second chancre which should be followed by the concomitant symptoms of general syphilis, without these we cannot admit of any case of reinfection. Some times the medical observer is led astray by a wrong diagnosis in those cases of reinfection by forgetting or not having the knowledge that syphilis is sometimes subjected to a relapsing induration which closely resembles the initial lesion, hence the error in the many cases of the so called reinfection. The most valuable diagnostic signs of a chancre, are, its period of incubation. Induration of its base without inflammatory engorgement, the ulcer being, generally, single, the edges sloping, flat, or rounded &

adherent, the floor being red & lined or coppercolored & often covered by a false membrane, & the secretion being scanty & serous, whereas in the chancroid is generally surrounded by inflamation, the secretion purulent & abundant, the floor "wormeaten" & the edges being abrupt as if they were punched out, & the ulcer generally multiple the neighboring ganglia become inflamed often & many times supurate & occasionally becoming virulent, & the disease is always local & the chancre is accompanied by induration of the neighboring ganglia & never take on inflamation except in some strumous subjects & [illegible] is always followed by a second period of incubation between the appearance of the chancre & the developement of general manifestations which

is subject to some variations but not
indefinate in its duration, During this
first period of incubation the virus lies in a
quiescent or latent state, giving rise to
no external manifestation of its pres-
ence from the moment of contact of the
virus to a period of 2, 3, 4, or 5 weeks
is this virus brooding the system
in a dormant condition & with great
certainty showing its effects at the point
where it was received within the above
mentioned [illegible], The duration of this
incubation depends upon the habits
& constitution of the patient. It is neces-
sary, then that this primary infection
must be constitutional from the
begining of the ulcer, Not [illegible] then,
but, that the virus has not permeated
the system, even before the appearance

~~has made its appearance, when so long~~
a time has elapsed from the moment
of contagion to the first appearance of
the chancre? As regards to the long period
of incubation of the chancre a few cases
have come under my notice, one parti-
cular instance is that of a young man
with whom I ~~was~~ am well acquaint-
ed, & having no object in view in de-
ceiving me, & being man of reputed
veracity, was 5 years ago exposed
to the influence from whence this
contagion generally originates, He being
married, stated, that his wife being an
invalid from uterine infirmities
& that he had abstained from sexual
intercourse, with her for fully 10 years
& being in town on a business trip
he was tempted to visit a house of

[illegible] for the [illegible]

33 days previus to this statement that he was in town, when he came to me with a mere abrasion on the inner side of the prepuce near the furrow, He also stated that he [illegible] connection with his wife the night previous to this statement, for the first time [illegible] 10 months, & being ignorant of any lesion on his genitals, although he watched him self from day to day, but feeling a smarting sensation during coi-tion he was induced to inspect him-self more closely the next day when he came to me with the above mentioned lesion, he ask me whether there was any serious thing the matter with him & whether he had contami-nated his wife, & told him that I [illegible]

[illegible]

[illegible] by all means [illegible] from his wife, & in a few days he had a well marked "Hunterian" chancre, His wife became also infected with a chancre just within 37 days from our first history, I have had under my care [illegible] other patients with chancres, according to their own acct with an incubation from 24 to 34 days, Syphilis is also followed by a second period of incubation from 6 to 11 weeks, from the appearance of the chancre to the secondary lesions, which consist of an eruption on one or more parts of the body, preceded by some or all of the following symptoms, feeling of malaise headache, stiffness & soreness about the

[illegible]
-ping [illegible] at [illegible], [illegible]
with more or less chills, [illegible]
pains of a wandering nature, which ex-
-tend deep down as if the bones were
affected, The complexion becomes
sallow, with a haggard & forlorn coun-
-tenance, & the patient looses flesh & be-
-comes generally cachectic in appearance,
yet all these symtoms might pass
away, even without treatment, leaving
the patient with a some what broken
-down constitution, & be followed
again by similar symtoms & so on
for a longer or shorter period when
they might entirely ceased, These path-
-ological phenomina do sometimes occur
even with the best of treatment,
& Thus the disease in some cases seems

to be persistent, when the patient becomes chagrined with his supposed relapses & discouraged with his physician & it is well for the surgeon not to deceive his patient by the promise of a cure within a specified time but should tell him, that the suppose relapses should not be reguarded as such, & that it is the nature of syphilis to have its course by one or more attacks; & that he should trust to the powers of nature with proper treatment & hygiene for the elimination of the poison from the system,

I saw one particular case of this kind of a young man, whom I knew, had been under a surgeon's care of this city for two years, he stated that he had followed out his doctors advice very

closely during that time, when he came
to me with a much broken down
constitution & mucous patches in his
mouth of an ulcerative nature
his system was so much depressed
that I [illegible] feared to give him
mercury for his lesions, he was so
much worn out & disgusted with
his disease, that he remarked to me
"that he had been a walking drugt
store for two years", & whether he
had to suffer all his life for his-
folly, I put this man on tonic
treatment consisting of Cod liver
oil, Iodide of potash Iron & Bitter
tonics for [illegible] 5 weeks changing them
at intervals, with marked improve-
-ment in strength & flesh, but the
mucous patches did not seem [illegible]

much better during that time but which rapidly subsided afterwards under the judicious treatment of protoiodide of mercury. Another of the characteristic features of Syphilis, is its contagious property, It was held by the older writers that all the secretions were of an infectious nature (viz) the sweat, saliva, milk & semen & even the breath, This assertion does not hold true with the exception of the saliva which in itself is not infectious but becomes so in flowing over mucous patches contained in the mouth, & is one of the most fruitful sources in conveying the disease, Thus it is conveyed by kissing, & by the use of cups spoons, & pipes, &c that are used from mouth to mouth, Bumstead relates an

instance of the disease being communicated in this manner to quite a number of children by a toy vendor, (who was affected with mucous patches in his mouth,) by testing the horns, mouth organs &c. before he sold them, The blood in the early stages of the release is another infecting medium, reports have been made of obstetricians becoming infected by having abrasions on the fingers, which becoming imbued with blood in delivering infected women, The disease has also been communicated by vaccination the point of the lancet being stained with blood of an infected child, the same lancet being used in vaccinating healthy children, a remarkable account of this is given that occurred in Civalta by which means 20 persons became infected

~~The disease is communicated by~~

infected wet nurses to healthy children & vice versa, But the most frequent manner by which the disease is conveyed is by sexual intercourse the one or the other party being infected, & however the disease is acquired whether from a primary or secondary lesion it always commences with a chancre & runs its general course, Another one of its peculiarities, is its hereditary influence, & it is by this means only that it does not show itself in the form of a chancre The disease is transmitted to the offspring either of the infected parents, or both more especially in the early stages of the disease (the first two years) ~~But~~ which is modified to some extent by

treatment, but if both parents are infected the disease is very aft to be transmitted within the first 2 years, however thorough the parents have been treated, & sometimes it makes its appearance in the [illegible] when the parents have been apparently exempt for some considerable length of time, & it is well for the surgeon to advise his patient not to marry for several years after all signs of the disease have ceased, It has been stated by some authors that congenital syphilis has an agravated influence on the offspring, from the fact that many of them die in early life, & many before full gestation & when it is transmitted from the infant to an invidual, it is said that its virulent power seems to multiply

[illegible] it
ground. The nature of Syphilis
depends upon its origin in a fixed
contagion, the exanthemata [illegible]
in a volatile or fixed contagion
They have fix periods of incubation,
Syphilis two, the exanthemata one,
which are followed by constitutional
disturbance & fever, Syphilis in this
feature being comparatively mild
The lesions of the former being always
inflamatory during the whole course
While in the latter, they are essential
- by proliferative & moderately hyperaemic
& the point of difference is that the ex-
-anthemata are simply inflamed, &
if proliferation occurs it is of a
simple nature, a mere increase of nor-
-mal cells, but the pustule occurs in

Syphilis, the inflammatory process is less active & always results in infiltration of new cells entirely passive in their nature. Syphilis has been classed by some to be a disease of the lymphatics & of blood disease, so far as these are affected it is true, although the lymphatics & ganglia are rarely affected by syphilis & although they are means of its dissemination & probably its occasional deposits of deposit, since the full development of syphilis takes place not in the tissues of either vessels or ganglia, but in the connective tissue to which these vessels are (therefore) by distributed It cannot be classed among the diseases of the lymphatics, For the same reason it may be said in regard to it being a blood disease, although it has its

found [illegible] in the secretions of active lesions & in the blood during an active lesions stage of syphilis, & not found to exist in the blood in the latest stages of syphilis though the patient be labouring under some of the more severe forms of the tertiary type, in which the cells become less frequent & when they do exist are old & inactive & are incapable of reproducing themselves & the blood no longer carries the molecules & it [illegible] its contagious properties & it [illegible] its [illegible] influence, & it thus it is seen that the active & infecting secretions existing in the primary & secondary lesions are found to consist of a serous fluid, containing numerous shining molecules which

are [illegible] [illegible] [illegible] [illegible] of
protoplasm, & actively increasing mor-
bid cells, conveying with them this
mysterious & unseen virus, & depositing
it in the connective tissue of the
periphery, and by preference & later on
the deeper tissues & internal viscera.
The period of latency observed in the
course of syphilis (according to a reliable
author) may be explained in
the following manner. Each outburst
is attended by the development &
multiplication of these peculiar cells,
which run their course, & are finally
absorbed, Some remain & after a time
are excited by unknown causes to
activity. Thus repeated exacerbations may
occur, each one depending upon the
multiplication of cells remaining, &c

[illegible]

But each relapse is less active & less prolonged than its predecessor, untill perhaps only one nidule remain, & that composed of effete cells, the disease might be then considered cured. This explanation may seem to apply imperfectly to those cases of prolonged latency in which no lesion whatever has been perceptable. Virchow thinks that in these cases the lymphatic ganglia have been the places of deposit of the syphilitic cells, which at the expiration of the period of latency, undergo these changes mentioned. In any case, the specific cells or the virus that developes them, must be hidden away somewhere in the system, since the continuation of the disease depends upon

their [illegible] With this [illegible] of the nature of syphilis & its effect upon the general health may be accounted for, & it is the absorption of these cells by the wonderful powers of mercury, that so much good can be obtained in the treatment of syphilis. In speaking of the pathological anatomy of syphilis I shall not go into any details any more than mentioning that in the secondary form it attacks the skin & mucous membrane reserving later on the deeper tissues & internal viscera, the periosteum the osseous & nervous system, All individuals are not affected in like manner, no one having all the lesions & pathological

changes dependent upon the disease, but there is no tissue of the living body that is necessarily exempted from the grasp of this "Protean" muster.

The Progenies of syphilis is not necessarily fatal nor, yet is it necessary that every case should run into the tertiary form, though [illegible] cases come to an unfavorable end, & sometimes end in death, when either nervous centers, air passages, lungs heart & bloodvessels, & other internal viscera are seriously affected, though the number of cases (owing to the present mode of treatment,) are rare in comparing the vast number that have been seized within its [illegible] grasp, Dodge seems to have divided his syphilitic

[illegible]

[illegible] Syphilis has a tendency to decrease & the other class it which it has a persisting power to increase, the former he treats by hygiene & tonics holding mercury in reserve & in the latter he resorts to mercurials & with great difficulty in controlling the symtoms, Lastly I will make a brief notice on the treatment of Syphilis. The chief remedies that are indicated from wide experience & satisfactory proof, are mercurials, Iodine & its compounds the former acting on primary & secondary lesions, the latter on the tertiary type, The susceptibility to a given lesion to one or the other remedies will indicate to which stage of syphilis it belongs. But

[illegible]

-cation in respect to treatment, between secondary & tertiary lesions but a gradual transition from one to the other. As the disease progresses Iodine gradually begins to exercise its remedial power. The so called transitional stage by Ricord requires a combination of Mercury & Iodine, lastly tertiary symptoms yield with great facility to Iodine & with difficulty to mercury. Yet it is doubtful whether the former agent without the assistance of the latter can effect their permanent removal & again the effect of [illegible] in some cases supposed to be produced by syphilis may not be syphilitic infection but act as an agent in putting into

action [illegible] dimes which [illegible]
existed in a latent state, which
sometimes account for them not
yielding to the specific remedies.
In treating patients with Syphilis
in the stage indicating mercury
most any of the preparations of mer-
cury in use will do, as the Pillulae
Hydrargyri, Hydrargyrum cum creta
Calomel &c. When there is an indi-
cation for speedy mercurial action
or when the patient seems not to be bene-
fited from the use of one of the prep-
arations, the combination of sever-
al mercurial preparations may produce
the desired therapeutical effect, with
more promptness. Owing to a diminution
of blood corpuscles, properly called ~~Hle-~~
~~ro-aen~~ Chlorosanaemia which exists

in the early stages of syphilis, requires some tonic to be combined with the mercurial, such as the following Rx Pillulae Hydrarg. ℈ii, Ferri Sulph. Exsiccati ℈ß, Ext. Opii gr. v ℥ss, Sig. divide into pills no. xx one to be taken 3 times a day. Or quinine may be administered with the mercury both for its tonic effect & rendering the mercury less liable to salivate, a morbid influence which should be carefully guarded against. There are some persons very susceptible to the effects of mercury & can be salivated with a very few ordinary doses, & care should be taken in these cases to stop the drug as soon as their symptoms come on & after the symptoms of salivation have subsided to administer the drug cautiously, i.e.

[illegible] [illegible] [illegible]

[illegible] [illegible] [illegible] [illegible]

[illegible] [illegible] [illegible] [illegible]

[illegible] [

Iron, Iodide of Potassium & Chlorate of Potash as a gargle occasionally swallowing a small quantity during the day.

Iodide of Potash & Iron used alternately seems to have a powerful & rapid influence in restoring the blood to its normal condition in this stage of the disease, furthermore the surgeon should be careful in administering mercury to a patient that has been run down by the disease, presenting a cachexia of a [illegible] type, with a marked degree of debility, & accompanied with functional disease of the heart, In extreme cases of this kind I do not think that it is time wasted in postponing mercurial treatment, for a short time & resorting to the vegetable & mineral tonics adapted to the complications that arise.

[illegible] of mercury [illegible]

during this critical period the more powerful preparations should be used such as the Bichloride or the Biniodide in very small doses in combination with the bitter tonics. Persons of a scrofulous diathethis do not bear mercury well except in combination with Iodine & then it should not be continued long at a time, or better use in combination with internal use of Iodine, mercurial inunction even this form of treatment in some cases, seems to agravate the disease, or wrather the scrofulous complication. One special case of this kind came under my notice, was that of a young man of a strumous habit, became infected

[illegible]

with the disease, before the glands of the neck became enlarged & assumed a bluish colour (belonging to scrofulous glands) which [illegible] into a suppurative stage & assumed a [illegible] appearance & seem to become aggravated under small doses of Bimiodide of mercury, which I [illegible] using & employed mercurial inunction with internal use of Iodide Potash & Bitter tonics with still no benefit, & I was obliged to discontinue the mercurial treatment. I then put [illegible] on Lugol's solution with the Compound fluid Extract of Stillingia in the interval, with marked improvement inside of ten days, & a perfect healing of the suppurated glands within five weeks. This man had several outbreaks of syphilis afterwards, for which

I [illegible] with very small doses of the
Bi-iodide in combination with other
tonics & cod liver oil, As it has
been the experience of almost every
surgeon in watching the course of syph-
ilis & the effects of [illegible] upon the
same, that under the most rigid treatment
the patient will have two or more
outbreaks & in others the disease seems
to defy all treatment for a time, (i.e.)
the patient will have repeated outbreaks
for twenty to thirty months, which
would only perhaps yield to treatment,
only soon to be followed by another
attack & so on until the disease seems
to wear itself out, and that mercury
acts on lesions present by far, more
promptly than preventing subsequent attacks
As having already stated that syphilis was

depends upon a specific [illegible]
produced or caused a proliferation of
morbid cells & which cells caried with them
this supposed ferment, or non isolated
virus & that mercury has a specific
action in destroying these cells when
present, through the power of absorption,
& causing all syphilitic symptoms to disap-
pear, thereby removing ~~[illegible]~~ its depressing
& morbid influence, & giving the patient
a better chance to recruit his health, by
making him better adapted to withstand
& less susceptible to the next attack,
Thus seeing the immediate action of
treatment on lesions present, there are
few circumstances in which the sur-
geon feels more pride in his profession
or in which he can arrive at more
conclusive evidence of his power over

disease, than when he can recognize the symptoms which indicate the exhibition of these remedies & watch their marvelous effects from day to day. It is the immediate action of these remedies (Mercury & Iodine) on lesions of the more vital organs of the body, (the nerve centers & internal viscera) that the greatest amount of good is obtained, the patient being snatched sometimes as it were, in miraculous manner from the very "jaws of death." & there is no doubt that similar views upon the same subject, that induced the famous Ricord to advise the use of antisyphilitic treatment in those deep & ~~inex~~ inexplicable symtoms of cases, where you can get no direct history & even when the patient is

above suspicion. In regards to the action of mercury on lesions present & in treating the initial lesion as a prophylaxis against future attacks my argument as far as proof is concerned in regard to the number of cases under my observation, would be but poor foundation to rest upon, but I have seen some cases to convince me & to confirm what I have read from very good authors, to be of the same opinion. One or two cases I will draw a contrast, Case, 5 yrs ago, already mentioned, who contaminated his wife whom I did not give specific treatment for the initial lesion but kept him on tonics, untill secondary lesions appeared, which was an interval of 6 weeks from the initial lesion, which

consisted of one or two papules on the
forearm & mucous patches within the
mouth, I waited two weeks longer
for further development of the disease
but there was no more than the
previous lesions, his mouth got very
sore, I put him upon mercury & he
began to improve in a few days &
all the lesions entirely disappeared with
in two weeks, then I stopped the mer-
cury & put him upon local treatment
again, this patient had three other
mild attacks of mucous patches in
the mouth, (with lesions no where
else,) at intervals of 3 — 8 — 10 months,
for which he received treatment in
each successive attack, he had no
iritis or other complications & remains
efficiently well at present & has been

three years from last attack. The wife of the patient just mentioned seems to have been more unfortunate she becoming infected by her husband. as I have already stated, I treated her for the chancre (in order to keep down suspicion) which yielded to treatment within ten days, I continued the treatment with small doses of mercury combined with tonics for some 8 weeks but in spite of my treatment she broke out all over the body & limbs with a papular eruption, for which I gave her the protoiodide of mercury in medium doses 3 times a day, but yielded very slow, it was fully 6 weeks before the symptoms disappeared, she also had 5 other attacks including

a [illegible] [illegible] [illegible] [illegible] [illegible]

each successive time, I kept this patient nearly all the time in the intervals ~~between~~ of the attacks on small doses of Bichloride of mercury & Iodide Potash, occasionally stopping it for 2 weeks at a time & these symptoms kept up in quite a severe form off & on for 30 months from the time of her contagion to the disappearance of the last symptom & has remained apparently healthy ever since which has been 2½ yrs. There are various other remarks I might have made concerning this subject, although some things might have been left out & others inserted more appropiate which would perhaps have linked the subject together better, but as my time is limited I will have to present to you my kind masters this frail attempt of a

This is humbly asking your mem-
in passing your judgement upon it
So I remain your humble servant
& diligent student

Benjamin F. Shipley
Feb 10th 1883

A

Thesis

on

Diphtheria

by

R. J. Gilliland, Jr.

S. C.

1883.

Diphtheria.

History.— This disease of years to have been known, and to have occupied a place in medical literature at a very early period. Like a great many plagues which visited the people in those days, its visitations were followed by a great fatality. It has existed ever since, prevailing both in this country and Europe. We are indebted to Bretonneau, of Tours, for the first accurate discription of this disease, in 1826. The first appearance of this disease in this country as an Epidemic, beginning in California, in the year 1856. Since that time almost every

place in the United States has had some experience of it.

Diphtheria may be defined as "an acute, specific, contagious disease, beginning by an infection of the throat, and characterized by a local exudation and glandular enlargement."

Causes. Diphtheria is supposed to be propigated by a minute organism, which is known as the specific poison. As to the exact cause of diphtheria, of cause it is not definitely known. Cases have occured sporadically, where there was indeed no assignable cause for it. It is highly infectious

as much so as any other disease known. Several Physicians have lost their lives by blowing through a tracheal tube, the poison of diphtheria, which can be found in the Exudation and secretions, has been known to stay for some time on clothing. The poison may also adhere to the bed clothing, and to the floor, and walls of a room, As to how long, these particles of poisonous matter may remain in a room, after a case of diphtheria, it is not known, and indeed, it would be almost impossible to find out

Children have been known to take this disease six weeks after the last case in a house – the house having been thoroughly fumigated. Diphtheria prevails to a great extent as an Epidemic, and it may under certain circumstances prevail as an Endemic. We have seen it prevail as an Epidemic, where it would seem to have a special scope of country to go through. Nearly all the children in this scope of country would be attacked by the disease, while those, living even a mile away from the said scope of country,

would not be troubled in the least. Some persons are more susceptible to this disease than others. Old persons are rarely ever attacked by it. Children, between the ages of two and five years, are most liable to it. Infants are rarely ever attacked by it, but cases have been reported, where it has occured in infants only six weeks old. A temperate climate seems to favor the prevalance of diphtheria. Epidemics generally prevail in the fall and Spring of the year, but they may prevail at any time. Sudden changes in the temperature of

the Atmosphere may bring an
attacked of diphtheria. The writer
once suffered of a sinefle
attack of diphtheria, which
he thinks was brought on,
by riding twelve mile on
horse-back, after sundown in
the month of October. In diph
theria, there is always a period
of incubation. The time, from
the Exposure until the disease
makes its appearance, varies.
It generally depends on the
amt of poison taken in,
by the system, when an abra-
sion of the skin comes in con
tact, with diphtheritic Exuda-

tion, the disease will manifest itself in a very short time - 48 hours. Oertel, the great German Microscopist, places the period of incubation from two to five days.

Pathology. - Some writers attach great importance to the local lesions of the disease, overlooking the constitutional symptoms. Diphtheria is closely allied to Small-pox, Erysipelas, and Scarlet fever. Indeed, it sometimes follows one of these diseases. As agreed upon by most writers on the

Subject; diphtheria is a Toxaemia of the blood, in which the chief local manifestations are to be found, in the throat. As to what causes this toxaemia of the blood, it is not yet definitely known Several German Microscopist; among whom being Oertel, attributes the constitutional disturbances of the disease, to the formation of a minute organism in the throat, known as Bacteria. This question is not yet settled, but no doubt the time is not for distant when it will be; and new light will

be thrown on this cloudy subject. That the disease is a general one is well proved from clinical observation. Patients have died of the virulence of the disease, even before the exudation has had time to extend down into the larynx; and in some cases where there were scarcely any exudation at all.

Morbid Anatomy.- The first change that is noticed, is a hyperaemic condition of mucus membrane of the fauces. A short time after this, there is a pellicle formed in the soft palate of the fauces, or Tonsils. This pellicle

when it first forms, may be no larger than a pin head; but in a very short time, it greatly increases in size, and spreads over the entire fauces. This false membrane has a grayish-white appearance, and when minutely examined, it is found to be about 1/20 to 1/8 inch in thickness; and to be composed of fibrin including Epithelial cells, and having on its free surface Exudation Corpuscles, or fyoid globules and granules, these latter appearing only in the stage of degeneration. This exudation

in diphtheria has no tendency whatever to organization, or development. Diphtheritic exudation differs from croupous exudation in being thicker, more tough, and yellower. Several high authorities claim that they are identical, among whom being Morel Mc Kenzie, of London. While on the other hand there are several, who claim that they are not identical. It is quite probable that they are not identical, but it is very hard, in some cases to distinguish them apart. In croup the exudation is

easily removed; while in diph-
theria, it is harder to remove and
is deeper involved in the mu-
cus and sub-mucus membrane.
When the false membrane of
diphtheria is removed, it leaves
the surface irregular, owing
to the inner layers of the mucus
membrane being involved. In
croup the exudation is free,
and there is no irregularity
of the layers of the mucus mem-
brane, when it is removed.
A low form of organism is
usually present in pseudo-
membranous deposits of diph-
theria. The recent investigations

of Drs. H. C. Wood, and H. F. Formaxd have shown that micrococci are nearly always present in diphtheritic exudations. Whether these micrococci are due to the disease, or are merely accidental, is at present uncertain. Varieties,— Four varieties of diphtheria are generally given by most authors, Viz: Simple, Croupous, ulcerative, and Malignant. Such classifications however valuable they may be for scientific purposes, are often lost sight of in the general form of the disease.

Symptoms.— Diphtheria is gener-

ally ushered in by languor, general malise, anorexia, fever, nausae, and sometimes vomiting, and diorhoea is present. Albumine in the urine has been found in a large per cent of cases, In some cases, The initial symptoms may be so mild, as not to attract the notice of parents, or friends. The symptoms in mild cases are often like those of a cold. The patient may complain of loss of appetite, pain in the back, slight headache soreness in the fauces, and still be able to walk about, as if only

suffering of a slight cold, &c. In a great many such cases, the diphtheritic inflammation has already commenced, but is not found out until too late to do any thing for the patient. But in most cases the commencement of an attack is more severe, than above mentioned; being attended by rise of temperature, thirst, languor, and tenderness in the throat. Delirium, in some few cases, may be present at the beginning of the disease. The fever that usually accompanies an attack of diphtheria does not last longer

than three days, neither in mild
or severe cases. The temperature
often the third day is very near
normal. where there is continued
elevation of temperature often
the third day, complications
must be looked for. The tongue
is usually moist and furred,
the stools appear normal.
The respiratory track, in mild
cases, is not involved. Next to
the fauces, the mucus membrane
of the nose is most often involved.
The glands of the neck are usu-
ally enlarged and give pain
on pressure. In the Contagious
form, the above symptoms

usually continue until the fourth or fifth day, when the patient gets worse. The temperature goes up to 103°, or 104° F., preceded by chilly sensations. The usual symptoms of fever are then present. The pseudo-membranous deposit is at first of a greyish white appearance, but soon becomes of a yellowish-gray, or leathery color. This membrane forms in the throat so fast, as to keep up a continual effort to get rid of it. The swelling in the throat increases. The Saliva becomes more offensive, and from the fauces is exhaled a fetid odor,

which would lead one to suspect gangrene. If the disease is not arrest in this stage, the exudation of false membrane may extend down into the larynx, and also into the nose, as already stated, giving rise to an offensive discharge. About one half of the deaths from diphtheria occur from this form of the disease, i.e., after the false membrane has extend down into the larynx. In the malignant form, the usual symptoms are generally more intense, with vomiting and hemorrhage from the nose and mouth. The fauces in a very short time

becomes covered over with the pseu-
do-membranous exudation which has a
leathery, or ash colored appear-
ance. The tonsils may suppurate
or slough - the nares may also
be involved. Extreme prostration
comes on early. Death may take
place in three or four days, from
general constitutional disturban-
ces. Diagnosis - From follicular
inflamation of the tonsils, diph-
theria is known by the appearance
of the part; when the exudation
is removed. In diphtheria, the ex-
udation is limited to the sur-
faces of the mucous membrane,
accompanied by deep swelling

of the cervical glands. No other disease attacks so rapidly, the fauces, air passages, and nares. From Scarlatina, diphtheria is known by the absence of the brick-dust like flush in the throat and on the palate; and also the absence of the "Strawberry tongue". The tonsils may be involved in Scarlatina, but there is no tendency for the inflamation to extend down into the air passages. The high fever, the frequency of the pulse, and the peculiar rash of Scarlatina are sufficient to distinguish it from diphtheria. When the air passages are involved, giving

rise to the variety known as Laryngeal diphtheria; it is almost impossible to distinguish it from Croup. The pseudo-membranous deposit in diphtheria usually commences in the pharynx about the tonsils, while in croup it commences in the trachea and larynx. Croup is not contagious, occurs sporadically and is asthenic in its form. No albumine in the urine in croup, and paralysis never attends recovery from it. Diphtheria is distinguish from thrush by the latter always commencing in the mouth. Prognosis. No case of diphtheria is free from danger, no

matter how mild the first onset of the disease may appear. Among the unfavorable symptoms may be mentioned; a very rapid pulse, except when occuring at the commencement of the disease, early vomiting, profuse diarhoea, great prostration, delirium, a large amount of albumine in urine, hemorrhage, enormous swelling of the neck, and an offensive discharge from the nose. Sequelæ.— The most common sequelæ of diphtheria is paralysis, in various forms and degrees. In two thirds of the cases of paralysis after diphtheria the paralysis is limited to the soft palate. General

paralysis, paraplegia, diabismus, and paralysis of the muscles of the neck may also result from diphtheria. The palate nearly ever escapes when any other part of the body is involved. The paralysis generally comes on two or three weeks after convalescence. In many cases, however, the paralysis comes on later. The paralysis, which follows diphtheria, does not last long, in the majority of cases; and, as a rule, recovery takes place. Amaurosis is not an infrequent result of diphtheria. Various theories have been advanced to explain the nervous changes, which take

place. Some observers claim that the paralysis is of a centric origin, caused by impaired nutrition, brought about by the blood changes which take place, during the disease. Other observers hold that the paralysis is peripheral in its origin. The muscles of the pharynx, tonsils, and tongue supplied by the glosso-pharyngeal nerve are the parts first invaded.

Treatment,— The treatment of diphtheria may be divided into Kinds viz: local and general. No Specific has yet been found for the cure of this disease. Although several remedies have been highly praised

(as Specifics. It seems to me that
the most rational mode of
treatment would be to treat
the symptoms as they arise. The
emetic treatment, which is so
valuable in Croup, is not called
for in diphtheria, because it is
too depressing. Diphtheria is highly
asthenic in its nature; therefore
the greatest indication for treat-
ment is to keep up the patients
strength by giving plenty of nu-
tritious food. If the patient is
seen at the beginning of the dis-
ease, during the febrile stage, a
saline or mercurial purge should
be given, the latter is proba-

-bly the best. The dose should be repeated if necessary, Chlorate of Potash should be given, in doses to suit the age of the patient, every two or three hours. There is no doubt, but what Chlorate of Potash is one the best remedies in diphtheria, As soon as asthenia becomes evident, Tonics, Stimulants, Quinine, Wine &c. Iron, and good nutritious food should be given, when the condition of the patient calls for them. Some cases will require more alcohol than others. The Bi-Chloride of Mecury has been very highly recommended, lately,

by Prof. R. Mc Sherry, of Baltimore, Md., and Dr. Pepper, of Philadelphia, It is given in doses ranging from 1/60 to 1/32 of gr. The following treatment has recently been very highly recommended: To give a dose of Quinine, every Two or Three hours, from the commencement of the disease; and between the intervals of giving the Quinine, to give a dose of Tinct. Fr. Iron and Chlorate of Potash. Prof. Mc Sherry thinks that 1/32 of gr. of Bi-Chloride of Mercury combined with the two later preparations would be a good adjunct. The Tinct. Fr. Iron, and Chlorate of Potash

are probably the most potent agents in the treatment of diphtheria. The treatment of diphtheria with Mur. Fe. Iron is probably based, on its close resemblence to Phlegmanous, Erysipelas, pathologically. One to two grs of Calomel combined with ¼ to 1 gr Ipecac given every three or four hours, during the febrile stage is a very favorite prescription with some Practitioners. As soon as the fever gives way this treatment is followed by Quinine, Iron, and Stimulants. It is highly probable that Bi-Chloride of Mercury is a

remedy in this disease, an account of its being a good dishoyer of low forms of organisms. As has been already stated, good nutritious diet should be given, of which milk is the best. Local treatment. Nothing, as yet, has been found which will dissolve the pseudo-membranous deposit in the throat. Although the remedies which have been used for this purpose are too numerous to mention. Various caustic applications have been used, but are not recommended now, by the best authorities. Lime water, containing 5 gr of Carbolic acid, and a ℥j of Glycerine,

to every Two ounces) Sprayed on the throat every Two or three hours, is probably the very best local application. A gargle of a 10 gr Solution of Chlorate Potash, also should be used. I have seen good results follow the use of Turpentine, Applied both Externally and internally. The Atmosphere in the room should be kept moist by the escape of Steam, from Kettles filled with boiling water). The patient should get plenty of fresh air but not Exposed to a draft. When respiration becomes Embarrassed by the presence of False Membrane in the Larynx Tracheotomy should be performed.

1883

A Thesis

by

B. L. Gillam

for

Freshman.

Rubeola.

Rubeola, so called from the red color of its eruption and commonly known as measles is a disease of importance, though much less dangerous than some of the eruptive fevers; it is sometimes followed by very serious sequells and in some cases the disease is severe or even malignant.

Clinical History. The career of the disease is divided into three stages viz. invasion, eruption and desquamation, each stage claiming separate consideration. Stage of Invasion. The local symptoms are the

stage resemble those of an attack of influenza. There is coryza with frequent sneezing and an acrid mucus serous discharge from the nostrils; the eyes are irritable, reddened and watery and there is more or less intolerance of light. Subacute laryngitis frequently occurs and symptoms of bronchitis are nearly always present. In some cases pharyngitis occurs. The coryza, pharyngitis and bronchitis are thought to be due to the efflorescence which takes place on the

mucous membrane of the air-passages to that of the skin. The appetite is much impaired and in many cases nausea and vomiting occur; headache and debility are generally proportionate to the amount of febrile reaction. The general symptoms are often much severer than the local. In some cases convulsions exist while in others there is diarrhoea. Occasionally convulsions occur in this stage but chiefly in the primary chill. Epistaxis is a frequent

symptom in some cases.
False croup is sometimes
a symptom in very young
children. This stage generally
lasts about four or five
days. Stage of Eruption.
This stage may be ushered
in by a transient convulsion
but this occurs very rarely.
The eruption first appears
on the temples and forehead.
In a short time it extends
over the head and neck.
It is gradually diffused over
over the body and extremities,
its full development occurring
in about forty-eight hours.

At first the eruption [illegible] an appearance of small red dots or specks which soon enlarge, become elevated and arrange themselves in circular forms. The redness momentarily disappears on pressure. Increasing in size they coalesce and form blotches of variable dimensions with semi-lunar borders. The eruption proper to the disease sometimes shows not only hyperaemia, but infiltrated hineatin, the redness being with difficulty removed by pressure and a [illegible]

color remaining after the eruption has disappeared. The eruption is of a dull or deep red color. The portion of the skin not occupied by the eruption retains its normal color. There is swelling in proportion to the amount of eruption which is most marked on the face. About the fourth day of the eruption it begins to fade on the face and successively on the trunk and extremities. The symptoms denoting coryza, laryngitis and bronchitis continue during the stage of eruption.

Bronchitis in this stage gives rise to an abundant expectoration of mucous or yellowish sputa. On auscultation dry and moist bronchial rales are often heard. The eyes continue irritable and very often there is conjunctivitis. In the first and second days of the stage of eruption the temperature may be very high, but from this date in the natural course of the disease the temperature rapidly diminishes. The tongue is generally coated

Stage of Inflammation.

This stage begins when the eruption commences to fade and the duration is from four to eight days. More or less cough and expectoration are apt to continue after the eruption has disappeared and convalescence is not established. In some cases the eruption after having existed for the usual length of time disappeared. The case of the disease is from twelve to seventeen days.

Causation. Rubeola is a communicable disease and is not only received by those who are brought within reach of persons affected with the disease but it may be transported to a distance by means of fomites. The disease may be contracted from the clothes of persons who have recently visited patients with the disease; it may also be communicated by inoculation. Different authors varie the duration of the period of inoculation

from one to about thirty days but the most rare the attack occurs in from six to ten days after exposure. This disease is far more common amongst children than those of advanced life. It is most common in subjects under fifteen years of age. As a rule this disease renders the system unaffectable to it but exceptions to this rule are very uncommon. Diagnosis. The diagnosis

is generally unattended with difficulty after the efflorescence appears on the skin. The most important of the diagnostic characters are; the long duration of the stage of invasion, the affection of the air passages, the appearance of the eruption first on the face and its gradual diffusion over the body also the color of the eruption its papular character, the softness of its papules and its tendency to assume

a crescentric arrangement.
Early in the eruptive stage
there is some resemblance
to variola but the differential
diagnoses are that in rubeola
the schneiderian membrane
and air passages are early
affected also the stage
of invasion is longer
than in variola.
Occasionally there are
cases in which the cutaneous
efflorescence is not
abundant and the air
passages are not af-
fected, in such cases
the disease is sometimes

confounded with measles but the eruption in the two affections differs and such cases are rare. Prognosis. In most cases this disease is mild and not dangerous but in certain epidemics of cases it is severe and dangerous. The danger is generally due to complications such as capillary bronchitis, diphtheritic laryngitis, bronchitis &c. Treatment. In mild cases palliative measures and attention to hygiene

cold surface. The
cough may be relieved
by inhalations and if
the febrile movement
is great diaphoretics
and refrigerant remedies
may be used. The main
object in the treatment
of these cases is to
render the patient
as comfortable as
possible.
The patient should
be confined to a
room where the temperature
is regulated but one
with free ventilation.

To protect the eyes the patient should be kept in a room slightly darkened.
In complicated cases the treatment should have reference to the complications. Tepid baths, sinapisms or other rubefacient applications may be resorted to, in order to promote the appearance of the eruption but such measures as emetics, active stimulants,

The hot bath or over-
loading the body with
clothing are not to be
employed. The complications
do not occur in con-
sequence of the eruption
being delayed or insufficient
or striking in but the
later are rather effects
of the former. After
recovery from this
disease patients
should be placed
under hygienic influences
which will tend
to invigorate the
system with a view

to obviate a tendency
to the development
of Tuberculous and
scrofulous affections.

B. L. Dillon

1883

To the Faculty of the Medical Department of the University of Maryland,

Gentlemen,

I have the honor to present to your consideration this my Thesis, on =

= Intermittent Fever.,

trusting to your generosity, to overlook the many imperfections of this feeble attempt. And to remember me as one, a novice, necessarily subject to imperfectly developed ideas, of medical literature,

I subscribe myself

Very Respectfully

Your Obt Servant

H. D. Bisho

Intermittent Fever

Febris Intermittens, Fever and Ague
Characterized by paroxysms coming on at regular intervals, with entire absence of fever during an intermission

This fever is also known as chill and fever, and commonly called in some sections of country after the supposed cause, Malaria, Malarial fever. It is not attended usually with much danger to life, notwithstanding the fact, that the temperature runs very high, owing no doubt to the short duration of the fever, and the rapid decline of temperature, when the sweating stage becomes thoroughly established

Anatomical Characters.

Having never witnessed an autopsy of a person dead of intermittent fever, It will be impossible for me to state from experience, any thing pertaining to the Anatomical characters of this disease, But will give the statement of Dr. Flint, Bronzing of the Liver Spleen and Brain, which is found after death from, Remittent and, Pernicious Intermittent fevers, together with the presence of dark pigment in the blood. {Melanaemia} May be supposed to exist in more or less of the cases of Simple Intermittent fever, that end in recovery, Aside from these there are no known lesions characteristic of the fever

Clinical History

The clinical history will embrace an account of a Paroxysm and and an Intermission. The paroxysm being divided into three stages viz. The Cold. Hot, and Sweating stage.

Cold Stage.

The attack is usually sudden An individual after having been exposed to the condition necessary to propagate this fever May on getting up in the morning feel perfectly well. After a longer or shorter period he will complain of feeling tired His head, back and lower extremities begin to ache fits of yawning and stretching accompanied with chilly sensation down the back. After this

The skin presents a mottled appearance
and the finger nails become purple.
The yawning and drowsiness soon
cease, to be followed by a succes-
sion of rigors more or less severe.
The head ache becomes more and more
severe, and if the rigors accompany
the attack with any degree of severity
they cause the teeth to chatter, the
knees to shake, and currents of cold
running down the back, continue
for a longer or shorter period. Should
the patient attempt to warm himself
at the fire (which is often the case) they
will often complain of the part next to
the fire, being too warm, while the other
side seems to be freezing. The scalp
becomes tender, and he is uncomfortable when

touched or pressed upon, The whole
unexposed cutaneous surface becomes
cov- ed with goose bumps, The rigor
in some cases are so severe, as to
shake the bedstead upon which the patient
lies, There are a few cases on record
in which the rigors were present
without the chill sensation, This
however is rare, But we often have Chills
without rigors, In some cases the chill
is so slight as to attract very little
if any attention, This we call Dumb-
Chill, The chill being light, has no effect
upon the fever, Some practitioners even
claiming that when we have a light
chill, we may generally look for a high
fever, But this I think is not always
the case We may have both chill and fever

very light or both very severe, The cold stage may last only a few moments or may last several hours, The average time being about one hour Notwithstanding the fact that the surface temperature is diminished, the thermometer in the Axilla shows an increase of temperature The pulse is small and frequent, The desire for water great, indicating a congested condition of the internal organs. The patient has, generally a feeling of discomfort about the chest, with frequent sighing, and sometimes oppressed breathing, The blood not circulating at the periphery, must be sent to deeper tissues, Consequently the lungs become temporarily congested.

which, produces this disagreeable smothered feeling. The cold stage is sometimes entirely wanting, this being the exception rather than the rule, after lasting awhile and pursuing a course of greater or less severity it may lapse suddenly into the hot stage. But generally this change is more gradual. The chill going off, by degrees and the temperature rising at the same time. The patient will often complain of flushes of heat and cold, following each other in succession. These becoming more and more irregular, the flushes of cold disappear, and we have the heat predominating, which produces the Hot Stage or Stage of fever—

Hot Stage.

This may be considered the stage of reaction. The skin which was in the cold stage deficient in capillary circulation. now becomes freely supplied with blood. The pulse becomes rapid full and bounding. The lips which were during the Cold Stage, pale or of a bluish color, now becomes very red. The precordial oppression is greatly relieved. The headache increases as the fever rises, and in some cases becomes almost intolerable The thermometer in this stage shows a temperature ranging from 103 to 106, and in severe cases Even to 107 degrees. The patient during the height of fever, may become delirious, looking very wild, not recognising in some cases their best and most

intimate friends. But delirium is not a constant symptom. This depending a great deal upon the nervous condition of the patient, and not always upon the high temperature. I have seen patients very delirious with a temperature of 103 F while others with a temperature of 106 F did not appear to be the least nervous. This stage last from two to eight hours. The patient first breaking out with a gentle perspiration around the neck in the palms of the hands around the mouth and under the eyes. And finally the whole body becoming bathed in perspiration. The fever rapidly diminishing we have the third stage established, called the sweating stage.

The Sweating Stage

This stage being fully established, the patient begins to feel more Comfortable and will sometimes fall into a refreshing sleep, and not wake until the fever has almost or Entirely disappeared.

Dr. Flint says of this stage, that it is the means of bringing a paroxysm to a close is by no means certain. It is a sign of an approaching intermission and it may be an Effect rather than a cause of the decrease of the febrile movements.

There is one thing we do know and that is, when we have an intermittent fever with the temperature very high, we are always glad to see the sweating stage

And we hardly ever have an entire abatement of fever, without the sweating stage. The temperature rapidly declining as it is established. This stage lasting usually three or four hours, the fever entirely disappears, Giving us the period of.

Intermission

This period varies according to the type of the fever with which we have to contend. Those occuring every day are called the Quotidian. And the tertian type, is where we have the fever recurring every other day. The Quartan type which is the rarest form of the disease. The paroxysms recur every fourth day The first two being by far the most frequent form of the fever

There are cases recorded, in which these paroxysms make their appearance every 5th, 6th or 7th day. But I suppose these to be so rare as to only require to be mentioned in passing on to something of more importance When the period of intermission has a tendency to lengthen between each paroxysm it is supposed that the disease is abating and increasing when the period of intermission becomes shorter.
If I am permitted to venture an opinion here. I will state. That it seems to me that intermittent fever has very little tendency to spontaneous cure. And unless it is promptly and efficiently treated regardless of its disposition to come a little later each time

will Eventually terminate in what is
termed Chronic Malarial poisoning
and is accompanying trouble viz
Spanemia Enlargement of the Spleen and
Liver, Dropsy, Jaundice Functional
disease of the heart, which may become
Organic, Or the Lungs being the weakest
point may rapidly terminate in
Pulmonary Phthisis. So Malarial dis-
eases, Malarial fever, as a rule
complicate every disease with
which we have to contend.

This fever is said
to sometimes run spontaneously after
a few years—years. This is certainly an
exception, and not a rule, and I think
that those Exceptions are very few. The
patient may not have more than two

or three well marked paroxysms of Fever and Ague. But I think that if that patient was carefully watched it would be found, that he suffered with periodical pains of some kind, and that he would be found, becoming more and more anemic, all the time, until a course of medicine or change of climate cured him. Or the Malaria being overlooked he is treated for some of its complications, and thus finally ends his Existence.

We sometimes meet with cases occurring only in the form of a severe head ache, every day or every other day, or a severe facial Neuralgia, appearing only at night or at certain periods of the day, lasting a few hours and then

to return again the next day or day after. Fever readily yielding to Quinine Arsenic or other Antiperiodic remidies. During an intermission of this fever some persons will have a good opetite and feel perfectly well, with the exception of feeling a little weak. While others will loose all desire for food with the first fever, becoming weak and anemic very rapidly. And it is certainly very surprising to see a person subjected to a severe temperature day after day, ranging from 103° F to 106° F, and lasting from two to Eight hours, feeling, and looking comparatively comfortable until the approach of the next paroxysm does this show the wonderful endurance of man? Or does the person "[illegible]

with which his system is thoroughly impregnated, act to some extent as a food or fuel, for this excessive head and in this way protect the system against excessive tissue change to a greater or less extent, As this is a problem that I am unable to solve I will leave it at present for abler minds, and go on to speak of the

Causes

We know very little of the true cause of intermittent fever. Malaria, which has been so largely claimed as a cause, has by closer investigation proved to be simply a condition of a preexisting cause. Malaria, meaning bad air, throws very little light upon the true

cause of this fever. There are many kinds of bad air that do not produce Malaria. The Bacillus Malariae, which have been recently discovered by Klebs and Tommasi Crudeli, floating in the atmosphere of Pontine marshes, bids fair to supply to some extent the missing link in the etiology of this disease, and to draw the line of distinction between the bad air, produced by the presence of these germs, giving rise to malarial diseases, and bad air produced by various other causes which have no power to generate Malaria; but may produce other diseases. This Bacillus Malariae, when injected into the tissues of animals, is said to produce marked paroxysms

of intermittent fever. The Bacillus has been found most abundant in marshes particularly where we have brackish water; bearing the marsh and mud, exposed to the rays of the sun. The river beds of the southern states, And even the turning up of the soil of the high land fields in spring and fall the banks of the rivers and tributaries. Exposed to the rays of the sun at each ebbing of the tide all seem to favor the production of this malaria forming material.

Diagnosis

A simple case of intermittent fever can hardly be mistaken for any thing else The sudden attack; the short duration of the Cold Hot and Sweating

stage; the high temperature, and decided intermission, to be followed, after a certain length of time, by another paroxysm of the same kind, will certainly distinguish it from any other disease,

Prognosis

Pure uncomplicated intermittent fever is not attended with great danger to life; but by running unchecked after a certain length of time become chronic, and may in this way produce conditions which are incurable. And even in the acute form we may have an attack of pernicious intermittent fever, which is generally very fatal; but the simple acute form, when judiciously treated, is attended with but very little danger

Treatment

If there is any disease for which we have a specific, that disease is intermittent fever, and the specific the various preparations of Cinchona. But authors differ greatly in their opinion as to the necessity of what is termed preparatory treatment. Some claiming that it is very essential to give some kind of purge before using the specific, Calomel or blue mass, standing at the head of the list of these preparatory remidies on account of their supposed action upon the liver. While others claim that the preparitory treatment is not only useless but positively injurious, and that it is all worse to lose valuable time in preparing the system

to recover a specific, I know that a great many physicians along the course of the Cape Fear River, where these fevers are very prevalent, never think of using purgatives, unless indicated by obstinate constipation. While there are others who still cling to the old method of preparing the system. The writer being interested in those cases, has been a close observer of the different methods of treatment, and while the patients would be finally cured by both methods, the ones cured by the specific alone were as a rule cured in less time and the cure more permanent than by the combined method. The theory of this, is according to my humble opinion, that in the first place [illegible]

not being an exalted condition of the system but a condition of partial death, it is useless to give remedies to stell both reduce the powers of life, and by so doing we make more work for ourselves to do and prolong the convalescence of the patient, by weakening and were the framework upon which we have to build. In the second place if the disease be due to a poisoned condition of the system, due to Bacillus, Malariae or any other cause. It seems very plausable that we cannot get rid of that poison by severe purgation, as the poison is not situated in the bowel but in the tissue. And by purging we weaken the system, and the weaker we get the system, the greater will be the

influence of the poison upon it, And the longer and harder will we have to work with our specifics, Tonics Ferruginizing agents &c &c, to bring the system back, to its standard Sulphate of Quinine being the best of preparation of Cinchona, The dose will vary according to location patient &c. In North Carolina we give from 3 to 5 grains every 2 hours, for the first 12. or 18 hours, after a paroxysm, And if the paroxysms have a tendency to become obstinate, we treat with Quinine, Combined with some preparation of Iron, Strychnia and Arsenic, watching the patient and withdrawing the remedy for a while, when any unpleasant symtems, are manifested from the arsenic or strychnia, The cases that do not recover under this treatment are very few.

Albuminuria.

C. P. DeYoe.

arch. These arches are from one third to one half of an inch [illegible] ness. The cortical structure is composed of small tubes called the tubuli uriniferi and, of small red globules or [illegible]

Malpighian bodies, of blood vessels and, of connective tissue which [illegible] them [illegible].

The tubuli uriniferi and Malpighian bodies belonging to the [illegible] secretory [illegible], the connective tissue, the interstitial structure and the blood-vessels the vascular structure, making the [illegible] of which the kidney is composed.

The Malpighian bodies are globular

[illegible] $\frac{1}{104}$ of an inch in diameter and, red in color. They consist of a covering membrane called the Malpighian capsule which [illegible] a vascular tuft called the glomerule. The capsule appears to be the expanded end rather, beginning of the [illegible] uriniferi. Opposite the [illegible] into the [illegible] tubules are two perforations. These [illegible] the entrance and exit of the blood vessel, that enters [illegible] called the afferent [illegible] passing from the efferent vessel.

The afferent vessel after entering the capsule breaks up [illegible] [illegible]

These small branches make up the glomerule and after a more or less tortuous course in the glomerule they are collected and form the efferent vessel. The term "efferent vessel" is used in preference to "vein" since it carries bright arterial blood; showing that the blood passes into the Malpighian body to be acted upon & not to supply nutrition: The inner surface of the capsule of Malpighi is covered with a layer of either cubical or [illegible] epithelium; the glomerule is probably covered with similar epithelium. The convoluted tube leading from the Malpighian bodies is lined by

cylindrical [illegible] The [illegible]
nted tubes [illegible] greater part of the
volume of [illegible] [illegible]
[illegible] these
tubes are continued by [illegible]
ones, which are [illegible] form
the greater part of the [illegible] of the
medullary structure. In the base
they [illegible]
[illegible]
[illegible]
[illegible] distance, [illegible]
[illegible]
they pass into the [illegible]
and [illegible] [illegible]
longer or shorter course in the vertical
structure they [illegible] [illegible]

become straight tubules which unite with others and are continued to the apex of the cone, where they form an ansa.

The medullary substance of the kidney is composed of cone shaped masses of straight tubules. These masses are called the pyramids of Malpighi. The base of the pyramid is toward the surface of the kidney the apex directed toward the pelvis and one or more of them unite to form an ansa. Blood vessels and connective tissue are found in the medullary substance as elsewhere.

Blood supply of the kidney

Distribution of blood vessels

The renal artery

the kidney is of very large size when compared with the size of the organ supplied. (Renal). It enters the kidney through the [illegible] at the hilum. It then [illegible] into four or five branches. While in the [illegible] these give off smaller branches which supply the surrounding kidney structure and numerous branches which are distributed through the columns of Bertini. They [illegible] toward the surface of the kidney giving off small branches on either side: these branches are the afferent vessels to the Malpighian bodies. Other branches pass from the apex to the base of the

pyramids of Malpighi.

The efferent vessels pass from the Malpighian bodies and anastomosing form a dense plexus around the tubuli contorti. [illegible] plexus [illegible] near the surface of the kidney and another at or near the bases of the cones.

The [illegible] these plexuses.

The number of calices varies from 7–8 of Malpighian pyramids from [illegible]. The infundibula are three in number and are formed by the [illegible] of the [illegible]. The infundibula above the other [illegible]

between the other two, open into pelvis of the kidney.

Owing to the arterial pressure serum of the blood is pressed through the vessel wall of ~~the~~ the vessels composing the glomerule. In this serum the epithelial cells covering the glomerule act passing water and some soluable matter and retaining the remainder which is resorbed. Thus we have the kidney everywhere composed of three structures (1) the secreting or parenchyma (2) the connective tissue or interstitial, (3) the blood vessels or vascular.

Causes of Albuminuria.

Either of the three structures and parts of kidney may be the seat of the disease causing albuminuria.

When the disease is of the parenchyma it is called tubal nephritis.

When of the connective tissue it is called granular kidney or interstitial nephritis. When of the vascular structure it is called lardaceous, waxy or amyloid degeneration.

After reading a short time tubal nephritis and lardaceous kidney will produce granular disease. A granular disease will produce tubal nephritis

Causes of [illegible] Nephritis.

Cold is the most frequent cause of nephritis in adults. The patient being exposed usually when fatigued, as a person [illegible] from a journey which has exhausted him may be his clothes are damp; he sits in a draft in this condition & takes a cold which is very [illegible] to attack his kidneys. This more common in the temperate than in the [illegible] tropical zone. Exposure [illegible] this disease in the temperate climate would not [illegible] [illegible] the kidneys perform [illegible] which are performed [illegible]

other organs in other regions. They alternate more with the skin [illegible] elsewhere. Nephritis may be the result of a [illegible] which would produce [illegible] in the [illegible] dysentery in the tropical regions. [illegible] by cold the [illegible] is [illegible] [illegible] shortly after death blood drops from the cut surface. Intense inflammation here as elsewhere tends to produce rather [illegible] fatty degeneration. Nearly occurs after 40 years of age. Scarlatina is the most frequent cause of nephritis in children. In adults this is a [illegible]; [illegible] being a disease of child-hood.

The throat and skin appear to be the main passages by which the materies morbi produced by scarlet fever is eliminated. When the throat is most affected the kidneys are often but slightly affected and vice versa. The kidneys and skin appear to alternate with each other in a measure.
The partial suspension of action by the skin, throws an increased amount of work upon the kidneys. This may set up an inflammation of the kidney. The inflammation begining around the glomerule and extending. It is sometimes called disquamative nephritis when it

about the [illegible] to [illegible] we [illegible]
the [illegible] of [illegible]
[illegible]
[illegible]

Malaria When a patient has been subject to chronic malarial [illegible]
[illegible] A case of the [illegible] which had [illegible] [illegible]
to me at one of the medical clinics during the course. The patient [illegible] florist had been subject to attacks of malarial fever for some time and this had [illegible] been the cause of the existing kidney [illegible]
Measles [illegible]
diseases as typhoid [illegible]

give rise to nephritis. Rheumatism and Gout are probably [illegible] of Renal irritants [illegible] [illegible] the most important [illegible] is most [illegible] of any irritant capable of producing this [illegible]. Vapor of alcohol has apparently caused albuminuria and dropsy.

Many other [illegible] may be mentioned: Turpentine, Cantharides, Phosphorus and arsenic and [illegible]. Causes of Interstitial nephritis or granular kidney.

Granular disease may have its origin in acute tubal nephritis. It is undoubtedly a disease limited to the [illegible]

erate region. It occurs most frequently in males after 30 years of age although it may occur in early life. Oftimes it cannot be referred to any definite cause nor it be said when the disease began. There is, as facts establish, an hereditary tendency. Lead poisoning is a not infrequent cause of granular kidney. It may first produce gout, then acting with gout cause granular kidney. Deposits of urate of soda occur in the substance of the kidney [illegible] gout. The gout caused by alcohol with high living is more

apt to affect the small joints.
Frequent or chronic congestion
[illegible] alteration
in nutrition and a fibrosis of the
kidney. Any disease therefore
which causes congestion of the
kidney predisposes the kidney
to the change consequent upon
congestion. Pregnancy, partly by
the pressure exerted upon the
renal veins and partly by its ten-
dency to draw blood to the abdominal
viscera, will act as a cause.
The albuminuria is usually not man-
ifested until the uterus has risen
in the abdominal cavity.
Heart disease may act as a cause

Disease of the valves of the heart causes that organ to throw into the arteries an excess of blood at times thereby producing congestion of the several organs. Fibrosis of the kidney or granular kidney is produced as the result of this congestion, but the disease of the heart usually produces death before this disease (Fibrous) becomes advanced.

Causes of Lardaceous disease.

~~usually~~ This occurs with and may be caused by profuse suppuration. It may occur at any age. It may be a complication of Hip-joint disease of long standing or of Phthisis. Suppuration may

from us this effect by taking from the blood certain essentials as potash salts & white corpuscles & other organs as the liver, spleen and bowels are immediately affected.

Pathology.

Either of the first stages of the kidney may be the seat of the disease as stated.

When the disease is of the secreting structure the kidney becomes increased in size and darker in color. It is smooth and the

capsule is not adherent. The epithelial cells enlarge & increase in number. The enlarged bloodvessels may press upon and close the tubuli uniform and cause suppression. The epithelial cells become granular and when treated with acetic acid the granules do not disappear showing that the granules are albuminoid and not fatty. In a late stage the granules become fatty. The pyramids become bright red after this condition has existed the kidney becomes softer.

In most acute forms the interstitial portion is not affected. If it lasts for some time the interstit

tial portion takes on inflammation
When death occurs it is due to
suppression of Urine and there
is forming the casts are
the products of the inflammation
having coagulated in the tubes.
They may be moulded out of the
urine. They may be transparent
(hyaline) or granular, with linear
lines or cells or they may contain
the debris of amorphous cells or
they may be covered all over with
cells, or they may be blood-casts.
Blood casts are most common
in the renal pyramids they are not found
in granular kidney or in chronic
disease. Fatty degeneration never

takes place as an acute process. It is one process by which destroyed tissue is removed. It is seen as streaks following the tubules and, is always present in granular kidney. When the nephritis becomes chronic the kidney becomes large white and mottled and, the interstitial structure becomes involved. The tubes subjected to the inflammation may become large white entirely abounded of epithelium. This form may pass into granular kidney.

Acute interstitial nephritis is purulent inflammation caused by pyaemia, or by extension from the bladder (surgical kidney)

The process which brings about contracted or granular kidney is essentially chronic. When the process is not complicated by acute nephritis nor lardaceous, it is never larger than the healthy kidney. The surface of the kidney is nodular. The capsule is adherent and in the later stages bits of the cortex will come off with the capsule. The cortex becomes much thinner and of a yellowish color. After some time the contraction becomes extreme. As the connective tissue contracts it closes the tubuli uriniferi and this produces little cysts by the backing up of [illegible].
The blood-vessels become thickened

When heart disease is present the diuresis does not take place. The blood being backed into the kidneys it is in a state of passive hyperaemia and some of the colouring matter of the blood is deposited in the kidney, owing to this the heart retains its brown or chocolate color. The early stage of granular kidney is not accompanied by albuminuria There is always increased arterial tension in the early stage of this form of inflammation of the kidneys. In acute tubular nephritis there is always dropsical effusions. In one third of the cases of granular kidney this effusion does not

occur at least not until the last few weeks of the disease; proving that we may have granular disease of the kidney independent of tubular nephritis, that it may exist as a primary disease.

Gardaceous disease, or disease of the vascular structure. This is not a disease limited to the kidney but occurs simultaneously in various parts of the body. The morbid deposit acts as an irritant and causes nephritis. The kidney becomes enlarged and the capsule somewhat adherent. The arteries of the glomerule are first to undergo the morbid change

The diseased condition of the arteries causes them to be more permeable to fluids than normal. The arteries between the tubes become affected and by their enlargement and exudation constrict the tubes and produce cysts above the constricted portion. Fibrine finds it way into the tubes, with the elements of the blood capable of producing fibrine, and casts are formed. A few of these casts may present the peculiar color, characteristic of the materies morbi of this disease, when treated with Iodine, but most of them do not contain this peculiar substance.

Symptoms of Albuminuria.

Symptoms of Parenchymatous Nephritis.

Nephritis is due to [illegible] patient while perspiring [illegible] a chill [illegible] to [illegible] action. After a time he may [illegible] with a chill, then fever, [illegible] and the face is observed; at first of the [illegible] it may become general. The urine may be almost suppressed, the small quantity passed is dark (owing to its mixture with blood corpuscles). After [illegible] for [illegible] it may coagulate spontaneously. [illegible] fibrine elements contained in it. Pain in the [illegible]

prominant symptoms. In the severest form of the disease the patient dies within a few days from uraemic poisoning, but this is rare. The symptoms [illegible] gradually. The [illegible] of the [illegible] the condition of the urine are the prominant symptoms. The serous cavities may become the seats of effusion after the disease has lasted for some time; in pleura & pericardium more frequent than ascites. When these effusions occur they bring with them their characteristic symptoms Dullness, Succussion, symptoms of [illegible] mation may take place in other tissues usually the pleura and [illegible]

Headache and vertigo are common symptoms. Vomiting usually precedes uraemic convulsions. Albumen is present in the urine usually from the beginning. When a case ends in recovery, as nephritis tends to do; the urine is increased in amount sometimes beyond the normal. The dropsical effusions disappear. Albumen and casts are no longer found in the urine. These disappear gradually. Granular disease is chronic. It comes on insidiously. The patient and his physician may have no knowledge of when the disease began. He may have been taken ill in health for some time, dating after exerting himself

but little. At times the urine contains albumen casts and the sp. gr. is increased, while at other times it is quite normal. When the disease has become established albumen is usually present in the urine. The amount of urine discharged may be somewhat increased. Dropsical effusions may appear early in the disease, but in 3 of the cases they do not appear at least not until the last few weeks of the disease. Apoplexy is not uncommon in this disease owing to the fibrotic condition of the arteries. Apoplexy may produce hemiplegia or death. The retina becomes anemic and retinal hemorrhage is not uncommon. Casts are present in the urine these may contain epithelial cells, but are

an [illegible] stiffness of [illegible]. Movement of [illegible] is diminished. The [illegible] coming [illegible] being [illegible] [illegible] [illegible]

Treatment of Albuminuria

Treatment of Nephritis

Cups may be applied to the lumbar region over the kidneys counter-irritation is often of value The bowels should be kept open Diuretics do not act as well in these cases use Potass. Bitart. mag. Sulph. etc. Stimulants should not be given or if it be called for it should be given very guardedly since patients having nephritis are easily narcotized The diet should consist principally of fluids milk &c. Nitrogenous foods increase the amount of urea and do with it they increase the amount of work to be performed by the kidneys

With a free use of water and restriction of diet to nonnitrogenized substances for food many cases will recover.
As the growth of epithelium is very luxuriant unless secretion is sufficient to wash the products of waste from the tubules they [illegible] ted. Therefore diuresis should be encouraged, the skin and bowels should not be called upon to do [illegible] the [illegible] altho these should be kept acting [illegible] to relieve arterial tension. The diuretics should not be stimulating as they increase the amount of congestion. Digitalis is highly recommended with Tr of Iron.
Should dropsy present itself it should

be treated with purgatives. Accumulation often used is ℞ Potass. Bitart. ʒi
Jalap gr x

Mag. Sulph. Hot baths, and diaphoretics. It may be necessary to use hydragogues as Elaterium gr ½ gambogue &c but these are quite depressing. During convalescence the patient will do well on some tonic, of which Fr. Ferri Chl. is the best. Alcohol may be called for. Convulsions are best treated by the inhalation of Chloroform during the convulsion and the administration of Chloral Hyd. and, some of the Bromides, best Bromide of potassium during the interval between the attacks. The action of the skin should be solicited should uraemia supervene

Hot air and hot water baths promote cutaneous action and should be taken together with cathartics.
In treating granular disease the hope of a curative result cannot be entertained
The disease is written in indelible characters in every portion that has been invaded by it. All tissue once destroyed cannot be restored to its normal state, still its progress can be stayed, and suffering alleviated.
Vegetables should comprise the chief articles of diet. Change of climate is of most importance, from a temperate to a tropical or semi-tropical.
The disease is rarely if ever cured by these measures still, life can

many instances much prolonged by them. Dropsy should be treated as in nephritis. Acetate of iron may be given with acetate of potash. Alcohol should be avoided as much as possible. Diuretics may be called for: coparium (decoction), digitalis, juniper squills, bitartrate, acetate & citrate of potash. Inflammatory complications should be treated as when they arise independent of this disease except that opium should be be avoided.

The treatment of lardaceous disease consists in removing the cause, so long as the primary disease remains the deposit continues. If the cause be syphilis it should be treated with

appropriate remedies. Extensive suppuration should be treated. Tonics Iron Quinine &c should be given. Iron is best because of powers of promoting the formation of red blood corpuscles. Potash and other alkalies are useful. They supply to the blood the alkalies which are taken from it by the discharge. Liquor of Potash and the acetate are the preparations most used. They should be given with cod-liver oil and other tonics. Tropical effusions should be treated as in granular disease. Opium is better borne than in granular disease.

E. A. WAREHAM

Diphtheria

Argument

General History

Aetiology.

(a) Predisposing Causes.

(b) Exciting Causes.

Pathological Anatomy

Symptomatology:

(a) Course

(b) Duration

(c) Termination.

Diagnosis,

Prognosis -

Treatment,

Conclusion.

General Introduction.

The knowledge of the human body, the preservation of health, the recognition and cure of diseases, are objects of too great importance for me to doubt, but any attempt to promote them however slight would meet with an indulgent reception from any Professors in medecine. An inquiry into the intimate nature of Diphtheria it is presumed, will be thought to be in some degree interesting to some. There is no subject in the theory of medecine upon which more reasoning has been founded, nor any from which more inferences have been drawn

— for the medical treatment of certain diseases than the theory of their Bacteria origin. Those affections which we know, or at least believe, must originate through the infection of the system with certain peculiar poisonous matters, and which are mainly distinguished from the ordinary poisons by the fact that they can reproduce themselves under favoring conditions to an endless degree. And when investigations have been prosecuted further in this direction infectious diseases will be found to occupy a far wider field than now is commonly given them."

The argument I have given will present (it is hoped) (the matter

in a logical sequence so that should the arrangement of data or the reasoning drawn therefrom contain unwarrantable conclusions or any assertions that may seem to conflict with the prevailing ideas on the subject they may readily be detected. As the inquiry is made from the accumulated observations of the most eminent men of the day it is hoped that the conclusions drawn from them will meet the test of a candid examination.

[1] Ziemssen's "Cyclopaedia". Vol 1 page 574". by Oertel.

General History

Diphtheria is one of the oldest epidemic diseases of the human race.

Even Homer and Hippocrates advanced views from which Bretonneau first sought to prove that the disease was known even in those days under the name of Ulcus Aegyptiacum, as a disease specially to be feared as a preventive against the malady a combination of sulphate of copper with honey was recommended. This remedy has retained its position in the Pharmacopoea (Germ.) for centuries under the name of Unguentum Aegyptiacum.

Besides these notices, Aretaeus (at the close of the first and beginning of the second century after Christ) gives a

most characteristic description of the Malum Aegypticum, in which he especially emphasizes the fact that the Tonsils are covered with quodam, concreto humore albo, which spreads over the tongue and gums.

The ulcers, which are found on the Tonsils, and which are clean, small, superficial without inflammation, and painless, are benignant.

while on the other hand those which are extensive deep pruind and covered with a white, livid or blackish clot usually to be malignant.

In fatal cases the fetor which comes from the mouth of those affected with the disease, is so lothsome that the patients themselves cannot endure it,

Fluids are regurgitated through the nose, and there is hoarseness and loss of voice. When the disease extends quickly to the air tubes, it produces death in a short time by suffocation. Children who have not reached the age of puberty are frequently attacked by this disease.

This disease originates, according to Aretaeus, Egypt, Syria, and especially in Coele Syria whence it derives its name of Malum Aegypticum or Egyptian and Syrian ulcerations.

Macrobius describes a similar epidemic disease in Rome in the year 380 A.D.

In later centuries the disease —

-appeared again as an epidemic
first in Holland in 1537.
When Forest wrote an account of it.
Then in the seventeenth and eight
-eenth centuries it extended over
other portions of Europe.
In citing these more general
descriptions we call attention
to the fact that are not to be recei-
-ved as exact, as they do not always
avoid confounding the disease with
other affections such as Scarlatina,
etc. The first accurate inves-
-tigations into the nature of Dip-
-theria were made by Bretonneau,
and laid by him in the
form of two treaties before the
French Academie de Medecine in-

- 1821 Bretonneau first called this form of angina Diphtheritis - a name which he gave to the disease, because of its essential characteristic Exudation. According to this writer an inflammation, without exudation is never a diphtheritis. And no inflammation with exudation is diphtheritis, when it does not spread by contagion. and indeed the membranous exudation is the poison itself, which forms the pathological criterion for this disease. From numerous facts he believed he had proven that contagion occured only when the diphtheritic secretion, in the,

form of fluid or dust like atoms. came in immediate contact with soft mucous membranes or with the skin denuded of its epithelium. Inoculation he believed, was the only possible mode of conveying the disease, while the atmosphere, on the other hand, did not act, as a medium for spreading the contagion.

Finally croup and Diphtheria in Bretonneau's judgement, are one and the same disease and the latter, is ~~the~~ only the highest degree of the former.

Although Bretonneau at first insisted that diphtheria must be

considered as wholly a local disease, he was obliged at a later period to concede that a blood poisoning is one of its essential characteristics.

The discussion concerning the nature of Diphtheria assumed a new phase when the discovery was made by Klebs and Loeffler simultaneously that the Diphtheritic membranes the subjacent diseased parts, and even the blood, contained in great numbers vegetable organisms, or bacteria to which Loeffler gave the name of Micrococci; Pathological experiments were then at once undertaken to solve the disputed

question, by Trendelburg Nassiloff and others.

Etiology:

Predisposing Causes: -

While the disease occurs more or less throughout the whole range of civilization, it is more prevalent in the temperate regions. It is more apt to prevail as an epidemic during the winter and spring, but epidemics have occured at all sesions like all other diseases of the same kind. all the conditions of bad hygine increase its virulence and favor its diffusion. Unquestionably the chief cause of its spread is

"Bartholow's" Treatise Practice of Medecine, page" 740", second Edition

contagion, The young above one year, are more susceptible than adults, the greatest mortality being attained from the second to the fifth year.

Boys seem more apt to get the disease than girls a fact which Fothergill noted in the epidemics of the middle and the last century.

Exciting Causes.

As Diphtheria is a communicable and inoculable disease it is propagated by a specific poison. The form of which is not known, although suspected to exist as a minute organism. The simultaneous

i Ziemssen's "Cyclopaedia Vol i
page 595. by Oertel.

discovery by Hueter and Eberth of a minute organism of the Bacteria group, in the exudation, the mucous membrane, neighboring vessels and lymphatics and in the blood, has attracted attention to this parasite, as the infecting principle.

Virchows discovery of the presence of micrococci colonies in ulcerative endocarditis, and elsewhere furnishes strong support to this theory of diphtheria.

Pathology

Passing on now to a description of the disease itself we see that diphtheria when it occurs

epidemically, attacks especially the mucous membrane of the air passages, and from this point as a center infects the whole organism and becomes a general disease. As a local affection of the mucous membranes, its occasion the manifestations of an inflammation, the nature of which depends partly on the intensity of the local infection, and partly on the reaction of the tissues themselves.

(a) In the lightest forms we find in addition to diphtheritic equations which however may possibly be absent, only the signs of a catarrhal affection

(b). In other cases the inflamation is so severe as to cause fibrinous exudation (croupous form) on the surface of the mucous - membrane. -

(c). And the disintegration of the exudation followed by the process of decomposition, which in some cases may give rise to septicaemia. -

(d) Finally the inflammation may cause but gangrene of the part attacked though this occurs only in the worst cases.

Since a detailed description of the different lesions consequent on diphtheria would carry us beyond the limits of our subject

"Riemssen's" Cyclopaedia. Vol 1
page 576. by Oertel.

we will not attempt to go any farther with it, but leave what little we have said to the consideration of others.

Symptomatology.

Diphtheria of the mouth and fauces begins without symptoms which might give warning to the patient or his friends of the approaching danger, with slight fever or none at all with a slight sense of Malaise, trifling spontaneous pain in the throat, a sensation of dryness, or light pricking pain in swallowing, which in adults is scarcely noticed, and in children cannot be ascertained. The -

† Bartholow's Treatise Practice of Medecine page 745.

Submaxillary and cervical glands swell moderately and somewhat tender or painful on gentle pressure.

Only in rare cases does this light form of the disease give rise to more marked symptoms.

There are well marked forms of diphtheria:- The Catarrhal, the Croupous, the Septicaemic and the Gangrenous.

In the Catarrhal form the initial symptoms are those of an ordinary catarrh. Heat irritation and pain are felt in the throat and on the attempt to swallow much soreness experienced.

Croupous form:- This form may begin with and ordinary

Catarrhal variety and continue to the formation of the false membrane without any indication of a departure from the usual course until the fourth or fifth day when it takes on a new character by the sudden development of a high fever increased turgescence of the glands spread of the false membrane etc. —

Septic form: — During the course of the catarrhal or croupous form especially the later the products of decomposition entering the blood the condition of Septicaemia will be produced: —

Gangrenous form: — This is an extension of the septic form and should

be regarded so: —

Course — Duration — Termination.

The course and behavior of diphtheria have been sufficiently detailed in the preceding pages. The several forms briefly described are based on sound observation and experience which must always be confirmed.

The mortality of diphtheria varies greatly in different epidemics and and the results of sporadic cases are influenced by numerous causes. In some epidemics nearly all have died. So great is the variety in the severity of epidemics and of individual cases that no precise statement can be made.

It is certainly true that no case of

Diphtheria should be regarded as trifling for during the course of the simplest cases the most formidable symptoms may arise.

Neither secondary paralysis will develop after the termination of the disease, and what the nature will be cannot in any case be previously determined with certainty, but that diphtheritically infected wounds can be followed by paralysis of different groups of muscles should not be forgotten. [illegible] the infection of the mucous membranes, and the longer its duration prior the fall of false membranes. The greater is the probability that it will be followed by paralysis.

"Bemssen's" Cyclopaedia Vol I
page 660. by Vestel

Finally, in very severe cases certain groups of muscles may remain more or less hundred completely, even the others have recovered their functional capacity.

Diagnosis

Distinctive as are the symptoms with which diphtheria affects, in its clearly marked forms, yet it is quite often difficult in individual cases to decide if diphtheritic disease be present. In general one is less likely to err in the diagnosis during an epidemic of the disease than in sporadic cases, in which a definite distinction is often extraordinarily difficult. In the whole list of

Hartshorne's Essentials, page, 428,

subjective symptoms, there is no single one which would be completely indicative and conclusive in the diagnosis. And just as little possible would it be to give a complete and well define picture of a diphtheritic attack which would correctly represent every case at all times, a circumspect weighing of all the diagnostic points a careful review of the general symptoms, a close ocular inspection, and physical examination, a microscopical analysis of the patches, adhering to the mucous membranes are essential to form a conclusive opinion in doubtful cases.

From Scarlatina diphtheria —

is distinguished by the absence of the eruption, and of the peculiar punctated or brick-dust like flush of the throat and strawberry tongue. that Scarlatina predisposes to diphtheria, as a subsequent attack, is a well established fact and not unimportant.

Prognosis.

On account of the difference in the phases of development through which the diphtheritic process goes, the indications for prognosis are also different, and are preferably divided into two Main groups;

(a) Those which furnish a general indication of the course of the disease.

¡Reimssens Cycloffaedia Vol 7
page 668 by Oertel.

(c) Those from which only a special prediction for the next stage of the disease can be made.

Simple diphtheria is not very dangerous to life. The croupal form is decidedly so, and the malignant is fatal in a large majority of cases.

Insiduousness is a trait often belonging to the disease in children a name which has been applied by some for that reason, is creeping croupe! -

Treatment

In diphtheria we have to deal at first with an infection which is localized and afterwards with a general disease resulting from this.

out of which ultimately be divided still a later affection of various organs. Consequently the precise problems of treatment will be found indicated in the different phases of development of the diathetic process: -

We possess no specific remedies against the disease, but the basis of treatment will always have to be sum-total of our acquaintance with the special pathological process, its origin course & retrogression, and hence the treatment will have to be divided into. -

I Local.

II General: - and

III Treatment of the Secondaries.

The problems to be solved in the treatment of the local affection are; —

I. To treat the inflammation depending on the infection and its immediate results

II. To prevent syphilis disease and a general poisoning of the system

In order to solve the first problem, in a way corresponding to the knowledge and the remedies we possess we must endeavor to confine the disease to that form in which it comes under treatment, and prevent it from passing into a severer form. to put to stop. by every possible means to the spread of the processes and to bring about

a retrogression of the inflammatory process with the removal of the pseudo-membrane and necrosed tissues, where the exudation has already reached the mucous-membrane of the neighboring organs. The nose and the larynx to combat the symptoms resulting from it which jeopardizes life and finally to moderate the subjective symptoms, specially related to the inflammation — viz. the pain and difficulty of swallowing.

Among the requirements comprised in the second problem of the local treatment must always be counted early and most complete removal possible from the tissues

of all substances which cause the disease; secondly the arrest or limitation, by destruction of vegetable ferments, and other ferments of the decomposition going on in the products of the disease, and in the next place the most general disinfection possible, especially the cleansing the mouth and throat; and finally the prevention of any further entrance of Micrococci, and of the continued absorption of injurious products of decomposition from the surfaces of the diseased tissues

— General Treatment —

The treatment of diphtheria by

internal remedies is based upon the same principles as those which guide the administration of internal remedies in other infectious diseases.

As we possess no remedies which act directly to destroy or restrain the disease, or the virulent poison which causes it we resort, only, at the present time to those which meet the exciting indications. This mode of treatment has in its task. Therefore; —

1st To diminish and ward off the general constitutional disturbances the fever and the different complications which are likely to arise.

and which tend to keep up the disease and to diminish the strength of the patient.

2nd. To increase the patients powers of resistance, so far as this can be done by therapeutical and dietetic measures, in order that he may be able to live through the stage of reaction.

Treatment of Secondary

The successful treatment of secondary syphilitic conditions depends upon the possibility first of removing the pathological changes produced by the disease or at least of arresting

Nature in her efforts to do this or second of pertaining the functional powers of one organ until nature herself shall have restored the integrety of second organ upon which the first depended for the maintenance of its proper functions,

Conclusion

In conclusion I will simply state that it has been my effort in presenting this Thesis on diphtheria to bring forward and compare the various ideas and theories pertaining thereto that have been entertained during the last few years of course in the

endeavor. It was not my intentions and it would be almost impossible for me to give all the data relative to the subject which bears of such paramount importance. Has already been so extensively written upon that it seems almost presumptious for any one to offer more matter to the ever increasing quantity.

A Thesis on
"Lobar Pneumonia"
by
J. H. Robinson.

Respectfully submitted to the
Dean and Faculty of
University of Maryland.

Lobar Pneumonitis

It is an affection characterized, in its local manifestation, by inflammatory hyperemia of the lung substance, with exudation into the alveoli, of fibrin and serum.

In many nosological systems of present writers the disease is placed among the purely local affections, but it has come to be regarded by pathologists of more recent times as a general disease. Such is the view of Virchow who has suggested the name Febris Pneumonica and classified it among the essential fevers.

This author thus defines the affection: "It is a fever characterized anatomically by an abundant exudation deposit in

the air-vesicles of a single lobe, or of two, and sometimes three, lobes of the lungs with, in general circumscribed bronchitis and dry pleurisy. It is a fever which rapidly reaches its maximum intensity, and has a short career, the duration averaging about eleven days. It proves fatal chiefly in consequence of associated diseases, complications or accidents, and the mode of dying is by asthenia. It is non communicable and depends on a causes or on causes specific in character, the nature of which is at present unknown, but having relation to season and climate. It sometimes aborts spontaneously; and it is in some instances arrested by remedies."

Based upon its anatomical characters, the disease has been divided into three stages. The first stage includes the period when the affected lobe is in a stage of acute congestion or engorgement. In this state the lobules are inflamed interfering with the pulmonary circulation and giving rise to a true pulmonic fever.

During this stage the affected lobe presents a dark brownish red appearance due to the inflammatory process, and is somewhat heavier than the neighboring healthy tissue, but is sufficiently light to float in water.

Upon microscopical examination, the capillaries are widely distended and the air cells engorged with serum containing

red blood corpuscles in abundance with a few scattering white blood corpuscles.

The stage of engorgement is followed by the second stage or that of red hepatization, so-called from solidification and resemblance to parenchyma of the liver. During this stage the air cells become occluded and respiration is confined to the adjacent healthy tissue.

A cut section of the diseased lobe exhibits a dark granular appearance, exhibiting no crepitation on pressure, and if placed in a vessel of water will immediately sink.

The third stage should be favorable since a favorable crisis is reached, when absorption of exuded matter takes place,

[illegible]

That a very considerable portion of the exudation [illegible] admitted; expectoration contributing [illegible] little to the elimination of the exuded [illegible] stage.

When the fever pursues an [illegible] able course the third stage is that of [illegible] hepatization or the suppurative stage [illegible] the state of purulent infiltration, the disease usually terminates fatally.

During the first and second stages, the [illegible] in temperature [illegible] [illegible] or pleuritic [illegible] [illegible] in [illegible] stage [illegible] typhoid [illegible]

[illegible] [illegible] [illegible]
[illegible] [illegible] [illegible]
[illegible] [illegible] [illegible]

frequently accompanied by periodical fevers. The existence of typhoid symptoms such as [illegible] lassitude, [illegible] in the [illegible] and limbs, and as the disease [illegible] the muttering delirium with prostration and subsultus tendinum, constituting the true typhoid state, gives rise to typhoid pneumonia.

There is also reason to believe that nephritic and hepatic disease may exist simultaneously. Bronchitis which commonly prevails during the early spring months is such a concomitant to pneumonia that it is believed by many to stand in a causative relation to it.

Pleurisy although an inflammation of

a serous sac is so intimately connected with the parenchyma of the lungs that an inflammation of the latter can hardly exist without involving the former to a limited extent.

Phthisis according to some authorities rarely exists as a concomitant or sequel to pneumonia

Having thus far briefly considered the morbid anatomy, pathology and clinical history of the disease, I will now consider the diagnosis, prognosis and treatment.

Diagnosis of pneumonia is readily made without much difficulty; indeed, in many cases on sight. Patients themselves recognize in many instances the nature of the

malady, we have in pneumonia symptoms which are very distinctive if not pathognomonic. The affection as previously stated is ushered in with a chill, followed by fever with more or less pain in the side or pleuritic stitch adjacent to the nipple, with difficulty of breathing.

The characteristic rusty expectoration during the early period of engorgement establishes the diagnosis. Physical exploration of the chest however must not be overlooked, although the signs are distinctive; for the treatment will depend in some measure upon the amount of lung tissue invaded by the inflammatory process. Physical signs differ

in each of the three different stages.

In the first stage we have the fine crepitant rale or auscultation and moderate dulness of the affected lobe on percussion. The increasing solidity of the lung during the stage of red hepatization gives rise to increased dulness on percussion with no rale but a kind of whistling produced by the entrance and exit of air in the bronchial tubes.

When resolution follows the second stage, this bronchial respiration gives way to the crepitant rale and the dulness of resonance on percussion gradually disappears.

The differential diagnosis of pneumonia may be stated as follows

words. Indeed there are but few affections likely to be confounded with it.

From pleurisy, by the absence of the sharp, lancinating pain of the latter; by dulness of percussion and the crepitant rale.

From phthisis, by its sudden onset, crepitant rale and rusty sputa and the violence of the attack; and from bronchitis by bronchial respiration, bronchophony, and dulness of percussion.

Complications frequently accompany pneumonia tending to modify the diagnosis - e.g. Typhoid pneumonia, bilious pneumonia etc. In these affections we may consider pneumonia the type and the complications accidental circumstances.

Prognosis of pneumonia will depend upon a variety of circumstances which must be carefully considered. Uncomplicated cases when but one lung is affected and in a previously healthy subject [illegible] cases be recovered from, if the treatment has been judicious. Indeed such cases if left to themselves and in favorable hygienic surroundings, would in many instances recover.

On the other hand when double pneumonia exists and when the patient is aged, it is dangerous although recovery often take place in such instances.

Dr. Flint states that out of 133 cases which he had analyzed, in only two of the fatal cases were the [illegible]

ited to one lobe and not complicated or associated with other important affec-tions. The same author relates an in-stance where complete recovery took place in an individual whose entire lung was involved although he was situated in unfavorable hygienic surroundings and without professional attendance.

Mortality in pneumonia is due in a great measure to complications existing in the affection. Those which are likely to prove fatal are pericard-itis, intermittent fever and delirium tremens and sometimes affections of the kidney setting up uremic convul-sions. Some other affections may accom-pany pneumonia making the prog-nosis

unfavorable. Symptoms which may be considered unfavorable may be briefly summed up as follows :—

Frequency and feebleness of the pulse.
Great frequency and labor of respiration
Lividity of the palpebræ and face.
An abundant purulent or muco-purulent expectoration.
Bloody, dark colored sputa, active violent delirium; Low muttering delirium indicating the typhoid state, and albuminuria

The existence of phthisis cannot stand in a causative relation to pneumonia but may exist as an additional affection and add materially to the gravity of the affection.

The treatment of pneumonia says Hartshorne remains to be a questio vexata. This would appear, we apprehend, rather particularly to the onset of the attack or during the first stage. Blood-letting is lauded by some; by others condemned.

It is not the province of this paper to discuss the merits of this time-honored therapeutic measure. There can be no doubt however that in the early period of the attack and particularly in sthenic cases, good results may be obtained and with immense relief to the patient.

Since the physiological action of certain drugs is so well understood recourse to blood-letting need not be practised to the same extent as formerly.

Prof. H. C. Wood in his treatise on Materia Medica says on this subject "In sthenic fever it is desirable to relax ~~spasm~~ the peripheral vessels and promote a flow of blood to them whilst the rapidity and force of the circulation is diminished. A drug which depresses the action not only of the heart but also of the superficial vaso-motor nerves is here indicated, and if to these powers is added a special one of stimulating the perspiratory glands, the most perfect remedy is obtained.

The experiments of Ludwig, Schiff and others show that the blood vessels after complete dilatation, are able to hold twice the amount of blood. Thus by ...

of an arterial sedative which paralyzes the vaso-motor ~~sedatives~~ centers," we can bleed a man into his own "bloodvessels" or in other words get much of the effect of a resection by drawing blood from the diseased part." The robust and those of a plethoric habit need resection and undoubtedly this and be the best therapeutic measure that can be adopted,

With the aged and those of a feeble system, however, the operation would be fraught with the extreme.

While there may be differences of opinion with respect to resection and other therapeutic measures, the treatment is clearly not tentative. In the early forming stage of pneumonia, especially in sthenic cases

or in subjects upon whom we would employ venesection, quinine combined with morphia with perhaps one or two drops of Tinc. Aconite will sometimes produce a very desirable effect. Aconite, however, being a direct cardiac and arterial sedative should only be used during this early stage and not where there is much dulness and tubular breathing. The compound nitrous powder has also an excellent effect in the early febrile stage.

Where there is much pain and dyspnoea opium may be indicated, together with hot fomentations about the chest. A purgative of Epsom salts in the early period is recommended by some authorities.

These measures usually suffice in the early

period or during the first stage. Treatment of the second stage has for its object the promotion of resolution, allaying pain, and favoring expectoration when bronchitis is present. Supporting measures form an important feature in this stage.

Good nutritious diet is also an important factor in this period as well as in convalescence

We have thus far in the treatment, considered sthenic cases. In the asthenic, supporting measures must be adopted from the beginning. Beef tea, eggs, milk, spirits, with some of the preparations of Pepsin and Iron may be advantageously be used in such instances. Complications are perhaps more common in pneumonia than other febrile

affections and they must be treated as they arise. Typical cases of this disease are rare and the observing Physician, throughout the entire career of the disease will not overlook the condition of the bowels and kidneys and be prepared to meet any emergencies arising from morbid, Pathological changes or individual idiosyncrasies.

1883

"Whooping Cough"

By

B. B. Williams.

Whooping Cough

Although in the vast majority of cases the patients are children, it occasionally occures after childhood and at all ages. The affection has no anatomical characters except those of ordinary bronchitis. Other morbid appearances found after death are due to complications which I will mention under the head of clinical history.

"Clinical History" The names of this affection derive their significance from certain characteristics pertaining to the cough. The first or the forming

stage embraces a period prior to the appearance of these characteristics. The primary symptoms are those of simple coryza and bronchitis. Frequently during this period there is nothing which denotes the affection to be other than a common cold. But, in the majority of cases, the cough is more violent than in an attack of ordinary bronchitis and it persists for a longer time, progressively increasing. There is also more or less febrile movement which is more

marked and continues longer than in ordinary bronchitis
At length the cough becomes distinctly, and in a marked degree paroxysmal, and the distinctive features of the affection relate especially to the paroxysms.
The duration of this first stage varies from two or three days to two or three weeks. After the affection has advanced to the second stage. The patient is generally aware for a few moments previous to a paroxysm that it is impending.
A child engaged in play -

suddenly is quiet and the countenance expresses apprehension and distress. The morbid sensations are a sense of constriction, and an irritation of the larynx and trachea. These premonitions are sufficient to arouse the patient when asleep. The paroxysm is denoted by a cough which is characterized by a series of violent expiratory acts succeeding each other so quickly that the patient is unable to take an inspiration between them. The number

of expiratory coughing efforts which thus follow without an inspiration, varies, according to the severity of the paroxysm, from six to twenty. A long and labored inspiration then takes place giving rise to a crowing sound accidently due to spasm of the glottis; this is the whoop which enters into the name of the affection

Another series of coughing expiratory acts succeeds, followed again by the sonorous inspiration or whoop; and,

these alternate acts of coughing and whooping are repeated until the paroxysm ends. The contraction of the lungs by the spasmodic acts of coughing interrupts not only respiration, but the pulmonary circulation, so that an accumulation of blood takes place in the right cavities of the heart. These effects are shown by notable congestion and lividity of the face and turgescence of the cervical veins. Tears flow in abundance. The suffering from dyspnoea

is in proportion to the violence and length of the paroxysm. The contents of the stomach are frequently expelled; and, at the close of the paroxysm, more or less mucous secretion is expectorated. In proportion to the violence and length of the paroxysm the patient is fatigued or exhausted. However severe the paroxysm there is scarcely any immediate danger either from Apnoea or Syncope.

Various events are incidental to the paroxysms especially when

1

the latter are more. One of the most frequent of the incidental events is Hemorrhage.

Epistaxis is the most common form of Hemorrhage. Not infrequently blood flows from the nostrils. in more or less abundance with every paroxysm; and the loss of blood inducing notable anaemia. This favors the persistence of the Hemorrhage.

Haemoptysis is an occasional form of hemorrhage. Blood sometimes escapes from the conjunctiva. or ac-

-cumulates beneath this mem-
brane. Blood has been
known to be forced from
the ears. The primary &
chief cause of the Hemor-
rhage is the venous con-
gestion arising from ac-
cumulation of blood with-
in the right cavities of the
heart. The urine or faeces
or both are sometimes ex-
pelled involuntarily dur-
ing the paroxysm. Intes-
tinal hernia is sometimes
produced Certain com-
plications are liable to occur,

which add much to the gravity of the case. Mild Bronchitis is a part of the affection It is almost invariably present. If the affection be uncomplicated, physical exploration of the chest elicits good resonance on percussion, with, perhaps, the dry or moist bronchial rales. The Bronchitis in some cases is unusually acute, giving rise to febrile movement and abundant mucous secretions. Collapse of pulmonary lobules is liable to occur in young children. Pneumonia-

is developed in some cases
Pleurisy with effusion is an-
other complication, which is
more likely to occur in adults
than in children. These
several pulmonary compli
cations are rendered more
& dangerous by the recurrence
of the paroxysms of Whooping
Cough When Whooping
Cough is accidentally associa-
ted with some acute disease,
such as measles, or scarlet
fever, the paroxysms of cough
as a rule, become less fre-
quent and violent: These

intercurrent diseases interfere with the natural course of this disease. The duration of the affection is subject to considerable variation. Exceptionally the affection ends of its own accord in a few days, though it is rare for it to end in less than six weeks and sometimes it continues even for a much longer period than this—

"Pathological Anatomy" The only lesions are Hyperaemia of the mucous membrane of the nares, pharynx, larynx.

bronchial tubes, &c., increased secretion after a pulmonary dryness of the membrane, the secretion at first consisting of transparent mucous, afterward becoming more or less purulent and, when this condition has been reached; the redness of the membrane is succeeded by paleness and anaemia.

Various pulmonary and cerebral lesions occur also during the course of Whooping Cough, but these complications are not necessary to the disease.

"Causes" It is supposed that the special exciting cause of this disease is a contagious principle which acts upon the respiratory organs, with special excitation of the filaments of the superior laryngeal nerves. The morbific material may excite the disease at any age, but it is most common from the first to the seventh year, and it happens in females more frequently than in males.

Whooping Cough occurs among all races and classes, and is

more prevalent in Winter and Spring, although it is encountered at other seasons. As Epidemics of Whooping-Cough sometimes precede, accompany, or follow epidemics of Measles, a relationship has been supposed to exist between them. One attack removes the susceptibility to the disease, and it is uncommon for a second attack to occur in the same individual. The period of incubation, probably, about ten days but it varies considerably.

"Treatment". The Treatment of Whooping-Cough embraces curative and palliative measures. It must be admitted that there are no known means by which the affection may be arrested: that is abortive means. Measures are curative if they abridge the duration of the affection, or diminish notably its severity; and there are various remedies which possess more or less curative power.

Alum is considered as giving more decided and satisfactory results than any other remedy ever employed.

From one to six grains may be given every four hours. The dose being graduated to the age.

Dissolved in some form of syrup or water. it is not an unpleasant remedy. This remedy probably exerts its curative effect by acting upon the Bronchitis.

Of late the Bromide of Potassium and the Bromide of Ammonium have been employed to some extent with apparent results giving promise that these remedies will be found of value.

Palliative treatment is in.

portant. Relief may be afforded by opiates in small doses. if they be well borne. by Ethers and the Hydrocyanic acid.

Hygienic measures form an important part of the treatment. If there be no complications which interfere with exposure to the open air, this should by all means be advised and enforced. Under proper prudential restrictions. the more out-of-door life the better. The diet should be nutritious if. from the frequency of vomiting. the system suffer from innutrition alimentation becomes an impor-

taint object of treatment. The pa-
tient should take food often and
as soon after a paroxysm as possible.
The time for giving food should be cho-
sen as far as practicable remote from
the paroxysms and eating at the
most favorable times should be in-
sisted upon, despite the absence
of appetite. Hemorrhage, if pro-
fuse or occurring frequently, claims
haemostatic measures of treat-
ment.

1883

Thesis

On

Intermittent Fever

by

James W. Nixon.
N. C.

Gentlemen

Intermittent Fever.

Certainly no diseases are more worthy of careful Study on the part of Medical men than those of Malarial Origin, Owing to the last increase in the prevalence of malarial affection within the last few years, there are now many parts of our land where the physician is seldom called upon to treat any other diseases, And even when other ailments are met with, malarial complications are almost invariably present, The most common and therefore the most important Malarial disease is "intermittent fever"

Accordingly I shall endeavor briefly to describe its nature and treatment,

Fever and ague there is a complete intermission in this form of fever

There are three stages, Cold, hot and sweating

The Cold, Stage, temperature is increased within, the skin shrunk, sometime manifest pain in the back and loins, this stage passes gradually into the, Hot Stage, the skin resumes its shape and heat takes place of Cold, skin becomes dry and hot. Headache sometimes delerium, This is followed

by the Sweating Stage Skin becomes moist; sweat appears on the face first, then over the entire body, urine is of a brick dust color often containing increased amount of uric acid not infrequently albuminous matter, Sleep in this Stage is general and refreshing this Stage generally last from two to four hours.

Stermission is the Space of time between two successive paroxysms. The period from the beginning of one to the beginning of next paroxysm is called Stereal in distinction from Intermission. There are three distinct forms viz. Quotidian Tertian Quartan and two mixed forms

or Types. known as Latent Intermittent
or Bilious and Hemorrhagic,
Castilian form resembles Remittent,

fever, In this form the interval is about twenty-four hours, or the paroxysm recurs daily as the name implies,

Tertian form, In this type the interval is about forty-eight hours or the paroxysm recurs on third day, reckoning the days on which the two successive paroxysm take place.

Quartan type, The interval is about seventy two hours or the paroxysms recur on the fourth day As a rule, the paroxysms are uniform in each individual case.

As regards the cold stage, duration of the several stages respectively

the severity of each to compound
[illegible] [illegible] in different
cases.
The Quotidian and Tertian types
are the most common, either one
of these types predominate at
different seasons. We may have
Tertian in a locality one season, while
the next we may have Quotidian.
We may have double Quotidian and
double Tertian. These compound types
are rare except the Tertian form.
In this the paroxysms occur daily
but at different hours each succession
of days. These paroxysms generally
occur in the forenoon [illegible] at
at night. As a rule the paroxysms

recurs at the same hour each day, but sometimes there is a variation from this rule, Intermissions may be anticipatory or retarding, They are anticipating when they occur earlier than on the preceding day, retarding when later than on preceding day, This variation in time of recurrence is evidence that the disease is about to end,

During the intermission there is great difference in different cases as regards freedom from ailments, In some cases the patient is entirely free of a certain amount of debility the appetite and digestion being good and there is no apparent disorder

of any of the function while in other cases there is marked disorder of the functions, appetite and digestion being impaired &c

Complication

Enlargement, of the Spleen is an occasional Complication

The enlargement is felt though the walls of the abdomen; This Complication is known as "ague cake", In districts where the disease prevails it occurs in some cases before the disease develops, while in others of long duration it may be absent or very slight, it may continue for months after the paroxysms have ceased, The Pathology of this

enlargement is unknown, Anemia
is incidental to this disease
especially if it has been of
Considerable duration, The pallor
of the face often associated with
characteristic yellowish or sallow
tint and with oedema denotes
what is called "Malarial Cachexia"
General Dropsy is an occasional
complication,
Eruption about the mouth are frequent
The liver often undergoes changes
probably atrophy,
The kidneys also may be inflamed
congested containing albumen which is
apt to cease with eradication
of the disease,

Anatomical Character:

It does not exhibit any local inflammation except in complication

In the congestion of a chill the blood is broken up in the spleen and frequently it is carried to the liver and is more or less distributed to other organs.

The period of incubation is uncertain. It may remain latent for a time, The Duration of this disease is indefinite. It not unfrequently ends spontaneously after a few paroxysms, but in many cases continues for weeks and may for many months unless treated by curative measures, it is indefinite duration.

~~[illegible]~~ is a striking point of difference between it and a tumor fever. Another striking point is its liability to relapses. This liability remains for many years. In some cases successive attacks occur regularly at certain periods.
It was formerly thought that the tendency to relapse was lessened by letting the "fever wear itself out" so to speak.
Since it has has been proven that therapeutical interference will lessen the liability of subsequent attacks after the fever years have ceased to recur either spontaneously or from use of remedies

The Thermometer will show more or less increase of heat at the time the paroxysm was expected and as we have a rise of temperature occuring, the disease has not been completely cured and relapses are liable to occur

In Malarial districts we have what is called Latent Remittent Fever, or Bilious Fever in these cases the paroxysms are not fully developed.

The patient complains of indigestion ailments, The appetite is impaired nausia vomiting with pain in the head, indisposition to exertion. &c are present.

The tongue is generally covered with a white coating, these ailments are increased at regular periods on successive or alternate days with slight manifestation of a paroxysm. The Thermometer in the axilla will show periodical rise of temperature though the surface of the body may not show increased heat. The pulse is but little accelerated,
The temperature in intermittent fever generally ranges from one hundred to one hundred and six. There is also a form of Intermittent fever known Remembrance which prevails in the northeastern Section of North Carolina.

This form generally comes on in the relapse of intermittent fever, It may come on with any disagreeable feeling whatever before the attack is upon one.

Symptoms; The cold stage is, as in ordinary intermittent fever except that the duration is much longer,
The worm stage come on slowly and require the aid of stimulants Hypodermically.
The sweating stage comes on in from one to three days may never be perceptible
The Hemorrhages occur during

the Cold Stage from the Lungs
Stomach and kidneys
In mild attacks only one of
organs, is involved, all three
may be involved,
The patient may be improving
when he is attacked the second
time, There is great prostration
and coma.
The, Treatment should be as in
Intermittent fever except more vigorously
applied
Anatomical Characters unknown,
also, Pathology,
Causes of Intermittent fever, The Cause
involves a special morbific agent
malaria, This poison is called

miasm. It comes from where heat moisture and vegetable decay combine in decomposition, The exact source is unknown a temperature of 60° is necessary to promote this decomposition It is more abundantly produced when a dry is followed by a wet period in marshy sections it is abundant, more in night air than in day Its specific gravity keeps it near the Earth, as a family upon a hill will not suffer from it. While one in Ravine locality but in a bottom will.
The disease is not communicable from one to another and is purely miasmatic,

The Diagnosis, is plain, the type is to be determined by duration of intervals and a comparison of the paroxysms.
The Prognosis is good when free from Complications

Treatment.

Medicine - possesses Specifics if any remedies is entitled to this appellation, During Cold Stage hot drink, Tea, hot bottles warm blankets &c should be used Sulphuric ether and Carbonate ammonia are also good
In hot stage effervescent draughts nitrous powders &c give relief
In the sweating stage allow the sweat

to flow uninterrupted, Ice and Cold strictly prohibited. It requires careful nursing Cenchona has brought the disease under subjection, Sulph. Quinia is the best preparation of the bark to use.

Different authors differ in administration of Quinia Professor McSherry thinks grs xx, between the proxysms is all that is necessary in broken doses grs V every two hours, Hypodermic injection of morphine grs ¼ and Quinine in usual form, warm drinks sustaining agents may be employed When the Quinine does not break up the attack at once it is

better to give some purgative
as Calomel VIII to X. and then
go on with Quinnia Always
continue Quinia for several weeks
after fever, or relapse is apt to
occur.

Robinson Jan 1883

Syphilis

Syphilis, according to the most reliable authors, was unknown to the European Nation, until about the latter part of the fifteenth century (1494), about the time that Charles VI. King of France took possession of Naples; whether or not the army carried it there is not known. The French called it a disease of Naples, because it was unknown to them before they entered that place; the Italians called it the French disease. Some

contend that it first originated in America, that Columbus in his first voyage took it to Spain in 1493, one year before its appearance in Italy. Some contend that the soldiers subsequently ~~spread~~ extended the disease by a conveyance of the same on their return home from the Italian soil, while others do not think this the sole cause. Many attributed this disease to evil influence of the stars & not to sexual intercourse, while

others declared it to be
a disease of ancient
times, such as psoriasis
lepra &c., yet there were
still others who declared
that they [illegible] were seen
anything like it before.
The contagious ulcers of
the genitals, which were
known prior to the latter part
of the fifteenth Century, were
known as "Caries", "Caroli" &c.
This disease never appears
except as a result of
contagion. The real origin
of this disease is not
known. [illegible] states
that the bones of the Norigines

of this Cemetery, dug up
in the various States, Georgia,
Tennessee, Kentucky &c. show
traces of syphilis & he fur-
states that he believes these
bones to be the oldest syph-
ilitic bones in the world;
much of this tends to show
that this disease did first
originate in America.
But, again, it is stated
by other eminent author-
ities that syphilis existed,
& was treated with mercury,
many centuries before Christ.
Prior to the year 1852 the
idea was entertained that
all venereal sores were pro-

-egated
one virus & that the virus
of syphilis; of course, that
idea has since passed
away. The Chancroid is
entirely distinct from syphilis,
it does not depend upon
a specific virus of its
own. Chancroid is usually
gotten from a Chancroid but
it may be gotten from in-
flammatory products, espe-
cially debilitated subjects.
If any one be inoculated
with syphilitic virus & the pro-
ducts of inflammation it will
give rise to what is known
as "mixed Chancre". Chancroidal
poison has no comparison with syph-

ilitic [illegible]. The local venereal
sore is gotten from filth &
the products of inflammation
which does not usually
contain the syphilitic "germ".
The vesicles of herpes preputi-
alis may burst & give rise
to a chancroid.
Syphilis is a constitutional
disease resembling, in
some respects the specific
fevers, but the course of
syphilis is much slower &
is only communicated
by direct or indirect in-
oculation. There is also
a possibility of syph. being
inherited as well as ac-

quired, this is not so with variola, measles &c.

Inherited & acquired.

In [illegible] of cases hereditary syph. depends upon previous infection of mother. Acquired syph. is gotten from direct contact with a chancre or ~~primary~~ secondary lesion, particularly the mucus patches or from the inoculation with the blood of a syphilitic person. It was once believed that the primary lesion alone was contagious but such an opinion is not now entertained.

The lesions which are especi-

All characteristic of Syphilis
are 1st certain specific indurations
2nd a form which is known
as gumma or Syphilitic
tumour 3rd certain changes
in the tissues. The forms
are too much alike & it is
hard to distinguish one
from the other.
The syphilitic virus matter
of a person may be transmitted
to a healthy individual, by
means of spoons, drinking cups,
Catheters sponges, [illegible] should
be destroyed after using them.
1st Primary, 2nd Secondary, 3 Tertiary.
Primary stage. The chancre
doesn't make its appearance

under the 8th day, from the
time of exposure to the
contagion. The first symp-
tom of a constitutional
is invariably a chancre,
i.e. if the syphilis is acquired
in the ordinary way.
Superficial & deep (Hunterian),
either of these may turn
into the phagedaenic form,
the superficial is the most
common form. Chancre
usually results from contact
with secondary lesions, it
occurs as a reddish brown
papule, with an ulcerated
spot in the centre, but
sometimes covered with a

dry brownish scab. The ulcer is commonly circular or irregularly elliptical in shape, red in color & pours out a thin serous exudation, no pus unless much inflamed or irritated. If you take the ulcer between the finger & thumb, the margin & base will present a cartilaginous or membranous hardness, known as parchment like induration; sometimes before the ulcer heals this induration disappears. This chancre may be situated in the male urethra or upper part of vagina & thus escape

detection. The [illegible] chancre

has a very short period of incubation from 6 to 10 days. It is not much seen now as of former days. It presents a deep excavated ulcer with sloping elevated edges & a foul surface furnishing a serous exudation, sometimes tinged with blood; the base of the chancre is deeply indurated & presents a sensation to the fingers ~~to~~ like that of a split pea. This form of chancre is very persistent & usually arises from [illegible] but not always so. Induration is a characteristic of all forms of chan-

ce. Induration is developed within
in a few days after & even
sometimes before the appearance
of chancre. The period of indu-
ration last from 2 to 3 months
A chancre in most cases
is solitary - not so with chan-
croid which is commonly
[illegible].
Mucous patches are seen ~~[illegible]~~
where the mucous surfaces
are always in contact, as in-
side of the lips, tongue, the
inner surfaces of the
labia, the folds of the anus
& the lining surface of the
prepuce.
Bubo is an enlargement ~~of the~~ and
induration of the lymphatic

glands of the groin, these [illegible]
will nearly always find
with chancre. If the chancre
be situated upon the genitals,
the inguinal glands will be af
fected which causes the ordi-
nary syphilitic bubo. If the
chancre be about the head, the
facial & submaxillary glands
will be affected. Syphilitic bubo
is hard & movable beneath
the skin, nearly always painless
& about the size of an almond &
if suppuration [illegible], it is
thro' some externall irritant,
such as scrofulous diathesis &c.
The shortest period in which
an untreated chancre is known

to have been followed by secondary symptoms. is 25 days, the average period is about 6 weeks. Secondary Syphilis cannot occur without primary syphilis having preceded it. (Hered. S. an exception).

There are certain symptoms which precede secondary syph., these are, febrile disturbances, with languor, discomfort, pains of neuralgic kind headache of a neuralgic kind, with the exception of the headache, all these rest disappear in about 4 or 5 days & then the skin eruption, sore throat, mucous patches & general enlargement of the lymphatic glands, these are

the characteristic & usual manifestations of secondary syphilis. The hair frequently is seen to come out. The eruption is copper colored in the declining stage & minus itching. To this stage belong mucous patches, beautiful cases of which I have seen presented in the "University Hospital," Md.

Stage There is usually an interval between the subsidence of the secondary symptoms & beginning of the tertiary symptoms, altho' it sometimes occurs before the secondary stage has fairly ended. This stage may affect any tissue

of the body & it is called the stage of deposit. The chief cutaneous manifestations are the tubercular & squamous eruptions, this is usually found upon some portion of the face which sometimes cause great discomfort & disfiguration. These tubercles begin as solitary skin tumors. The squamous eruption usually takes the form of "psoriasis". Syphilitic psoriasis often attacks the palmer & plantar surfaces, then it is very characteristic of the nature of the disease. The tongue in this stage is often affected by mucous

patches. The tonsils fauces & palate often suffer in this stage from ulceration & this ulceration may extend so far as cause deafness, difficulty of articulation &c; the discharges are very offensive. The cervical vertebrae are sometimes attacked. The worst form of "Scitis" is seen in tertiary Syphilis.

ment Give patient all the mercury that he can take & that will be absorbed. Commence with small doses of "Blue mass" say gr. ss. at dose & then increase dose. Commence with 3 pills per day until you get up to 6 & if the breath becomes of a bad [illegible] & gums sore

discontinue the mercury for a few days & then commence again & so on until the disease begins to diminish & then you diminish the mercury. You must know how much mercury an individual can take. Patient must go on taking mercury until pox is ended & for 6 months there after. You must have patient under general tonic treat.
In tertiary stage still continue mercury & with the addition of "Iodide Potass"; the Iodide Potash holds the disease in abeyance while the mercury cures it. Where the nervous

system is involved give 25 grs
Iodide Potash 3 times ter in die
In giving mercury, if it should
purge add a little Opium with
it. The Chancre should be
kept clean & powdered with
"Iodoform", "Bismouth" &c. To mucous
patches, apply stick of Nitrate
silver. Chancroids should be treated
by keeping the parts clean &
from rubbing. Open the Chan-
croidal bubo & wipe it out
with fuming Nitric Acid.

John Albert Robinson

University, Md.

1883.

Syphilis.

John A. Robinson.

University of Md.

Feb. 20th 1880

Hart J B
1883

An
Inaugural Dissertation
on
Typhoid Fever
submitted to the examination
of the
Provost, Regents & Faculty Physic
of the
University of Maryland
School of Medicine
for the degree
of
Doctor in Medicine
by
Jno. Beauregard Hart.
1853.
Waverly, Balto. Co., Maryland.

Theses.

On Typhoid Fever.

The name typhoid signifies typhus-like.

Anatomical Characters.-
Typhoid fever has certain special lesions which are highly characteristic. They are seated in the Peyerian or agminate and solitary glands of the small intestine, and in the mesenteric glands. The first known of the changes which take place in the patches of Peyer and solitary glands, is enlargement from the presence of a deposit known as the typhous deposit, which probably takes place within the glandular sacs.

It has been supposed that the vascularity of the glands becomes increased and the deposit takes place as the result, but this is not fully ascertained. The enlargement is plainly perceptible, there being an elevation of the patches above the plane of the surrounding mucous surface a beautiful specimen of this kind was exibited to the class by Prof. Atkinson,. The mucous membrane over the patches is of a purplish hue, and the corresponding portions of the peritoneum are in a hyperaemic condition. The patches are indurated to the touch and present a granular appearance.

they have been seen as early as
the second day. The deposit ma
kes its appearance first in the
patches nearest the caecum,
and, successively, in the patches
situated above. Further on in
the course of the disease there
is a sloughing of the deposit,
mucous membrane, and glandular
bodies. This process frequently
goes on until there is a com
plete perforation of the intestine.
I might also mention here the
lenticular rose colored spots which
frequently make their appearance
on the abdomen & shoulders.
Clinical History.- Typhoid fever
generally develops its self gra
dually or it has a prodromic period

In the majority of cases, patients are unable to state the date of the commencement of the disease. The symptoms belonging to the prodromic stage are the following; Chills, more or less pronounced, sometimes followed by perspiration. Headache generally located in the frontal region. Loss of appetite, nausea sometimes vomiting. Epistaxis in the majority of cases. Pain in the limbs & back. Looseness of the bowels; lassitude & debility, so severe, indeed, are the latter that the patient feels compelled to go to bed. The most important of the symptoms above, as regards diagnostic value, are diarrhoea & Epistaxis

duration of the prodromic
stage is of importance in diagnosis.
Now, as regards the influence of
the disease, upon the general
appearance of the patient.-
There is no very marked alteration
of the countenance for the first
few days. The face in the early
period of the disease is generally
flushed. Afterwards, the coun
tenance presents a dull & stupid
appearance. Its influence on
the nervous system.- Headache
during 1st week which is persis-
tent & prominent. Delirium is
manifested in the majority of
cases. Other symptoms referable
to the nervous system are
subsultus tendinum, picking the cloths

Digestive System. — Almost always anorexia, though the appetite is sometimes preserved throughout the disease. Thirst is usually a prominent symptom until perception & the senses become blunted. The tongue generally presents a furred surface, but it is oftener covered with a thick coating of a brownish, whitish or yellowish color. When these coatings are exfoliated or thrown off it is a good sign of convalescence.

In severe cases we have sordes collecting upon the teeth & lips. Occasionally we have inflammation of one or both of the parotid glands, which sometimes suppurate & discharge pus into the ear.

Hemorrhage from the bowels occurs in a number of cases resulting from the ulceration of the peyer's patches through the small blood vessels of the intestinal coats.

The affection of the skin in Typhoid fever, I have mentioned, when I referred to the lenticular rose colored papulae that appear upon the abdomen.

Respiratory System.- A slight or moderate cough is almost invariably present, from congestion of the mucous membrane.

Laryngitis & oedema of the glottis occasionally occur in Typhoid fever; though they are frequently absent.

Circulation & Temperature.—

We generally, or, I may say always have an acceleration of the pulse in typhoid fever. The acceleration varies considerably in different cases and at different periods in the same case. As a rule, the danger of the disease is in proportion to the rapidity of the pulse; as for instance when it exceeds 120 per minute, the patient is in imminent danger, this rapidity denotes increased action, but not increased power of the hearts contractions.

As regards temperature, it is often above 101°(F) in the course of the disease; but, at certain periods,

the heat may not exceed, and never fall below, the standard of health.

If, in progress of the disease, the thermometer indicates a greater rise of temperature than 103°(F) the prognosis is very unfavorable, whereas, if it denotes a decline of temperature in the morning nearly to the normal it is evident that the patient is recovering.

The urine in "Typhoid fever is often scanty, and contains, in some cases, a trace of albumin." Prof. Mc. Sherry insists on frequent examinations of the bladder, in order to see if it be distended with urine, and if so, draw it off."

Causation. - Typhoid fever occurs
on every part of the world.
In malarial regions it is very
often blended with malarial
fever, and is known as Typho-
malarial fever. Young persons
are more susceptible to typhoid
than persons over 30 years of
age. It is said that the salivary
glands and glands of Peyer
begin to fade away after
adult-life. This will probably
account for the absence of
the abdominal lesions after
30 years of age.
Both male and female are
equally liable to the disease.
There is a special cause of
Typhoid fever; other diseases

do not seem to predispose to it.
There is no class of people exempted from its special causative influence.
As regards its contagiousness I think there is no doubt.
That it may be contagious under certain circumstances is certain, and that it frequently originates spontaneously, is I think equally certain.
Now then, we see that the special cause, as its termed, may originate without the body and be reproduced within the body.
For my part I believe the special cause or materies morbi is generated in & around cess pool

When I said "Typhoid fever was
contagious I did not mean
in the way that small pox
is i.e. by contact or approach;
but I did mean, that it
can be communicated from
one to another in some way;
as by the inhalation of the
gas, which emanates from
cess pools which, have been
used by typhoid fever
patients. This is not doubted.
The time from the introduc-
tion of the poison into the
system and the first mani-
festation of the disease, is
from one to two weeks.
Typhoid is a disease which
is rarely experienced twice.

Diagnosis. — Typhoid fever is to be distinguished from other essential fevers more especially typhus and remittent fever. The differential diagnosis cannot be fully considered without anticipating the diagnostic signs which belong to the clinical history of other fevers.

The distinction is to be made by ascertaining some of the signs which are diagnostic of typhoid fever, and the absence of symptoms diagnostic of other fevers. The symptoms in the clinical history which are characteristic of typhoid

fever are as follows: the onset of the disease being slow; the absence of marked remissions, the abdominal symptoms, viz., diarrhoea with yellow colored stools, and when perforation occurs tympanites, tenderness over the abdomen and gurgling; the occurrence of epistaxis and the characteristic eruption. Other points to be taken into consideration are, the season of the year, and the age of the patient. In the early part of the disease, the discrimination is not always easy, but after a longer duration

of the disease some of the diagnostic symptoms make their appearance, and the diagnosis is rendered comparatively easy. In this as in other diseases it is not well to make a snap diagnosis. Some delay should be made in order to arrive at a proper diagnosis of the case.

The local affections with which typhoid fever is liable to be confounded are, meningitis, bronchitis, pneumonia and enteritis.

Meningitis, as distinguished

from typhoid fever, is characterized by more intense headache, early and active delirium, a dread of light and noise. The abdominal symptoms are wanting, there being no tenderness over the iliac region. Constipation exists frequently, while it occurs very very rarely in typhoid fever.
Subacute bronchitis is a complement of typhoid fever. If the bronchitis be unusually prominent and the fever unusually mild, the latter may be overlooked and the disease considered a primary bronchitis.

This mistake can only happen in the early part of the fever.

Pneumonia often complicates typhoid fever, when pneumonia exists as a complication it is shown by its physical signs, consequently the physician should always examine the patients chest during the course of typhoid fever; in order to enable him to treat it in time if it arises. The physical signs in pneumonia we are all familiar with.

Prognosis.— The mortality is said to be about 18.62 per cent or, thereabouts, but I think it will be hard to state the rate of mortality; for the reason that there is considerable variation in the death-rate in different collections of cases occuring at different places and periods. The variation is often considerable at different seasons in the same locality, and under similar circumstances as regards surroundings and treatment. This fact is shown by the

number of deaths, in a given number of cases in successive years.

A fatal result, is, I may say hardly ever due to the disease per se, but is attributable to complications or accidents.

Treatment.— As typhoid fever is a continued fever attended with great prostration and cannot be aborted, the will treatment will suggest itself. It is the same as in all essential fevers, viz; principally supporting, this will consist in, quinine as a stimulating tonic and

to reduce temperature, Valentine's meat juice, plenty of liquid food; as milk, beef tea & so on.

The phycian should of course watch any given case and adapt his remedies, such as have given him the best results, to the symptoms and complications as they arise. Mineral acids are lauded highly by good authorities in typhoid fever. Probably I have been most too concise in dealing with this important disease; but nevertheless I am pressed for time, and I therefore ask to be excused.

As this disease is very prostrating I would like to say here a few words in regards to the administration of stimulants.
About the middle of the second week, or indeed, the time for its administration must be ascertained by the attending Physician. Wine whey, half a wine glassful about every 3 hours; later, when patient is weaker, brandy or whisky punch; a tablespoonful of brandy, for instance, every two, three or four hours, sometimes everyhour

with twice as much milk. Beef tea is indispensable in nearly all cases from the second week. It may alternate with gruel, hour by hour. As in typhus, a patient prostrated with severe typhoid fever should be waked from sleep to take the required nourishment, night and day; otherwise he will suffer for want of it. With this much, I must close, hoping the Theses will meet with the approbation of those to whom I have respectfully submitted it.

Thesis

on

Diphtheria

by

Wm. W. Watkins

1883.

Diphtheria

Diphtheria is a disease characterized by a tendency to the formation of false membrane; and which effects the dermoid tissues: as the mucous membrane, and even the skin.

History - It is a disease of antiquity, and has dated back for centuries, and has often been described by ancient writers, but it was only about 50 years ago that it received its now existing name, which was given it by M.

Bretonneau of Tours in France. Since the commencement of the 16th. century numerous epidemics have occurred in America and also in Europe, and at the present time is one of the most common and fatal disease in both Continents, which in many localities, especially in large cities it is established as an endemic.

Age— It is pre-eminently a disease of Childhood most of the Cases occurring between the age of one

and ten years under the age of one year the younger the child is less liable it is to the disease, and it rarely occurs prior to the 4th. month. It may occur in adult age, and often does.

Incubation — It is only in exceptional cases that we are enable to ascertain the incubative period of the disease. The incubation varies in different cases. It is from 2 to 8 days, with perhaps an occasional case outside these limits.

Etiology. It is an independent acute specific disease being ordinarily produced by a specific poison and is of a highly infectious nature. It is a disease communicable both through the atmosphere, and by contact. One attack does not protect the system from another. It is not only communicable from person to person, but is produced by foul exhitalations, as sewer gases. Those infections maladies which are accompanied by

inflammation of the fauces and air passages, are most liable to this complication, if they occur in any locality where diphtheria prevails. The inflammation of the mucous surfaces accompaning them.

Anatomical Characters — The exudation of diphtheria is found to consist of fibrin, a delicate interlacing network, epithelium cells more or less altered by the inflammatory process, leucocytes, nuclei, mucous and amorphous matter

It is generally penetrates the entire mucous membrane, so that no line of demarcation exists between. At first there is redness which may begin in any part of the throat, being accompanied with swelling, and increased secretion of viscid mucous. The redness spreads over the entire faucial mucous surface in a few hours, and then except the mildest cases the exudation makes its appearance, generally within a few hours from the commencement of the disease

and the deposit may commence at any spot such as on one of the tonsils, on the soft palate, or at the back of the fauces. At first only small specks being observed, which however speedily extend, and coalesce, so as often to form extensive patches, or even to cover uniformly the entire faucial surface. The patches vary in thickness, and they become thicker by successive layers being formed underneath. It is observed first as a greyish-white slightly elevated patch,

which cannot be detached from the mucous membrane without leaving a bleeding surface. As the pellicular deposit increases in thickness it requires a yellowish or dirty gray color.

Symptoms – The attack is sometimes abrupt commencing with a chill, more or less marked, followed by considerable pyrexia; or the disease may begin with symptoms denoting great prostration, but not infrequently the development is gradual, the patient complaining of various ailments,

and the characteristic affection of the throat being discovered only on inspection. After the development of the disease the symptoms are divided into general and local, the latter being referred to the joint affected with the exudation. Local - The affection of the fauces is rarely accompanied by notable pain, and hence a liability to overlook its existence. The extention of the false membrane over more or less of the buccal mucous membrane, tongue coated, cervical glands, tonsils and fauces swollen,

epistoxis and vomiting, desire for food diminished, or lost, albuminuria is not infrequent, diarrhea is a bad sign. In the majority of cases the mind is uneffected. The disease may extend to the larynx, and lips and nails become blue from impaired circulation and deficient aeriation.

Diagnosis - It consists of the formation of a pseudo-membranous deposit, which is pathognomonic. From Scarlet fever, diphtheria is distinguished by the absence of the eruption, and of the peculiar punctated

or brick-dust like flush of the throat and strawberry tongue. That Scarlet-fever predisposes to diphtheria as a subsequent attack is a well established fact. From membranous croup, though possible in typical cases in localities where diphtheria is not endemic, or epidemic is difficult if not impossible at the bed-side, in places where diphtheria prevails especially when there is little or no exudation upon the fauces. Some writers say that the commencement of the pseudo-membranous deposit in diphtheria is about

the tonsils, and pharynx while in croup it is in the trachea & larynx while that of diphtheria rarely extends, in any case below the larynx. There is no albumen in croup, and the sequelae of paralysis never attends recovery from it. The general symp. of croup are as much as in any other inflammation dependent upon the local infection, while in diphtheria the local symptoms are secondary.

Prognosis — The disease is always dangerous. It is much worse in children than in adults.

The chief signs of danger are implication of the air passages with consequent interference with respiration as well as the development of pulmonary complications, septic blood-poisoning produced by absorption from the under-surface of the decomposing pseudo membrane, but generally more frequent from diphtheritic blood poisoning.
Great discharge from nose, epistaxis, repeated vomiting, and diarrhea, very rapid and feeble pulse, presence of albumen in urine particularly

if it is abundant, and a sudden rise of temp. are bad signs.

Treatment. Although diphtheria has been one of the most common of the severe infectious maladies in this country during the last 25 yrs. Physicians are far from agreeing in reference to the mode of treatment. Scarcely any other disease presents such a diversities in type as this disease, from cases so mild that nearly all recover whatever measures be employed, to those so severe

that a large proportion die under the best possible treatment. Acceptance of the germ theory does not require us to believe that diphtheria is primary local for these organisms may enter and infect the blood through the lungs before any symptoms occur, but we are taught by writers that these organisms alight upon one of the exposed surfaces usually the fauces, and excite local inflammation, and if not promptly destroyed are apt to penetrate the tissue enter the blood and

established constitutional
diseases. Acceptance of this
theory evidently leads to the
employment of germicide
medicines, the so called
antiseptics, or antiferments, externally and internally the remedies to arrest
and destroy the vegetable
growths. Hence we use such
Antiseptics as salicylic
acid, Carbolic acid, Chlorine,
Permanganates, bromides, lime
water &c. The general treatment should be light nutritous and stimulant food
in sufficient quantity,

tonics &c. If there is constipation give a mild cathartic. If there is fever with hot skin give quinia gr. v every 4 or 6 hr. and cold drinks of ice water, or small lumps of ice. Give Tr. Chloride ferri to keep up strength. If there be a tendency to diarrhea stop it at once. If albuminuria occurs give diluent drinks, and tannic acid are especially recomended. Moist inhilations are beneficial. As a spray you may use glycerine — ℥i Carbolic acid gtt v and lime —

water ℥ xvi. Bichloride of
Mercury is said to be good,
as it is thought to kill
the bacteria in the
blood.

"Respiration"

Baldwin Day
Virginia

Why does Man Breathe?

To obtain a clear answer to this subject we must examine the function of respiration closely. The oxygen which enters into the circulation of the body through the lungs - comprises in weight to one-fourth of all the solids and liquids introduced into the stomach - It consequently exceeds in weight that of the dry food alone - This oxy-

gen is the main source of the good which man derives from breathing. This good is partly direct and chemical, and partly indirect and physiological. If we follow the oxygen in its course through the body we shall see how it benefits the breather both chemically and physiologically. 1st. The direct or chemical good includes several different operations. viz:- First. The Oxygen enters the cells of the lungs and is absorbed by the minute

vessels which spread over the cell walls, within these vessels it combines directly with certain constituents of the flowing blood & proceeds with it in its ceaseless current through the arteries & veins. The first purpose or duty of the blood is to build up the substance of the body to form or enlarge the muscles skin cartilages &c. We have seen in our course that the nutrition of the vegetable food is very similar in properties

and combination to the fibre
of the animal muscle
& to the skin of the body
still chemical investiga-
tion has shown that
it seems to be com-
bined with a certain
amount of oxygen, be-
fore it can actually
live, or is killed it is found
with the substance of the
body — This oxygen is
supplied by the lungs —
The first good function
therefore which the ox-
ygen absorbed from the
air does when within the

breathing animal is that
it helps to build up the
solid substance of the
muscles, cutaneous skin —
It forms part of the
material of which they
are necessarily com-
posed, & it is in this
sense that oxygen is
a real food, that we
actually live to a certain
extent upon it & are fed
by the air which surrounds
us — But only part of the
oxygen taken in is used
thus directly & for restor-
ative purposes — The greater

proportion of it is employed for very opposite though equally necessary & useful ends thus - Second. The body thus built up is not a permanent structure. It is constantly undergoing upon & renewal. The functions which the several parts of the body perform, wear it away. The muscles, liver, brain & bones, all waste and the substance rubbed off so to speak is removed from the body & replaced by new matter from the food. But before it can be re-

moved this waste matter must again be combined with oxygen when united with the proper proportion of oxygen the muscle is changed into new compounds which are soluble in water & are carried by the excretions through the kidneys & skin. Such are Urea and Uric Acid. In the tissues also sulphur and phosphorus exist as necessary constituents these are not contained in urea and Uric Acid, but they combine with oxygen

separately from various inorganic and glandular acids which would decompose it as soon as it left the body. Thus the carbonic acid and urea which are excreted by the kidneys

if allowed long to remain
within it -
Third - A third chemical
service rendered by the
organ is not least im-
portant. I think the
following a very illus-
trative example under
this head - If a fat an-
imal be stinted in its
food or be wholly de-
prived of nourishment
for some days its weight
will rapidly diminish. It
continues to breathe and
in its breath to throw
off carbon dioxide and

water vapor. Water escapes through the kidneys & skin & with it other usual ex-constituents of the fluid excretions as urea &c. The animal in giving off the materials of its solid sub-stance & at the same time taking little food to re-place them must nec-essarily lose in weight. If we examine the animal after this period of star-vation we find that the loss of weight & substance is most remarkable in the fat of the body. This

has diminished in far greater proportion than any of its other constituent portions. If again we enquire what has become of this fat, we find scarcely a trace of it in the solid or liquid excretions. It has been breathed away through the lungs and skin. Breathing was necessary to the continuance of life and carbon dioxide & water vapor were given off with the breath necessarily while the usual supplies

of food were withheld therefore the ingredients of this gas & vapor were necessarily taken from the substance of the animal. It fed so to speak upon itself for the time, the fat which had disappeared had been used up for this purpose —

The three immediate and direct chemical purposes therefore for which the breathing animal takes in oxygen, through its lungs & skin are to produce the substance of

the solid tissues of its body from the nutrition of its food to convert the waste parts of these tissues into Urea phosphoric acid &c that they may be more easily removed, & to change the starch & sugar of the food into the Carbon Dioxide & water which escape from the lungs & skin ——

II The indirect and physiological good: — But these chemical operations are attended by indirect physiological effects which

a subject that has
claimed the attention and

[illegible]
[illegible] the [illegible] its
borders are undermined and
[illegible] defined, and will be-
gin to [illegible] [illegible]
in three or four weeks;
leaving [illegible] [illegible]
[illegible] behind, [illegible] this [illegible]
[illegible] [illegible] [illegible]
[illegible] [illegible] instead of one
[illegible] without any [illegible]
[illegible]. Second variety,
Lore with suppurating Sub-
[illegible] [illegible] are [illegible], by
[illegible], under the name
of Ulcerative Syphilitic Depre-
mation. They [illegible] the [illegible]

guinea blands, [illegible] them
to enlarge and suppurate
without any breach of the
surface on the genitals.
The absorbents are effected as
well as the glands, and
specific abscesses are some-
times, though rarely [illegible]
[illegible] of the ab-
sorbent vessels, It is said
by some that [illegible] taken
[illegible] any of these [illegible] ob-
[illegible] the glands will inoc-
ulate the same if put in
it at any other place; and
at the same time the con-
tagion is destroyed at the

[illegible] that no other part of the body is affected by the original disease until the [illegible] from a vitiation, [illegible] [illegible] [illegible]

[illegible] [illegible] [illegible]
[illegible] [illegible] [illegible]
[illegible] [illegible] [illegible]

irritate by the rubbing of cloth
irritating substance. If
sore at its base is of a fu

The weak words partial

We have tried to speak
of Syphilis in those parts
that are most visible
to the naked eye, but
will conclude by saying
that it is visible some
times in all parts of
the body and is found
in all grades of society
the rich and the poor
the high and the low
and in the language
of another de Sairs neither
the King nor the [illegible]
Prognosis, — I think, with-
out one doubt, that if
the patient is stout

and hearty, and lives
where he can enjoy
pure air and good water
and good food, and the
use of antisyphilitic rem-
edys for at least two
yrs, he will undoubtily
get well, and will say,
those who do not enjoy
the same advantages
hygienically may get
well. Diagnosis,
sufficient has already
been said to convince
one wheather he has
syphilis or not, but will
repeat, of the history

in that of a sore, en-
larged glands, falling
of hair, eruptions on
the skin, sore throat
pane in bones &c. &c.
We must be convinced
that it is Syphilis.
Treatment,—
Iodide of Pot. and
Mercury are the remedys,
one to eliminate the
disease and the other
to hold it in check,
We may give Iodide of
Pot. as high as 100 gr
T.D. when the nerves are
affected, but we may

expect Iodism, then we should stop and give Iodide of Iodium, Calcium or amonium, We should commence with a small dose and go up untill he could take no more, and then stop when we find the disease is on the decline we might diminish the dose, Treatment for Chancre, Keep the parts clean and then dust with Iodiform and Calomel or use the Cautery, Treatment for

children, use external applications, and let it nurse the mother, we must not apply it to the parts more than once First say, under the arm, then on abdomen, and so on 1st one place then the other, Treat for constitution, If the pt. requires it, give him tonics, but of all, Mercur and Iodide of Potash, we may use them together - threw out the whole period, begin with a dose and increase until he can take no more